



Food Is Medicine Opportunities in Public and Private Health Care for Supporting Nutritional Counseling and Medically-Tailored, Home-Delivered Meals

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Food Is Medicine

Opportunities in Public and
Private Health Care for
Supporting Nutritional
Counseling and Medically-
Tailored, Home-Delivered Meals



CENTER FOR HEALTH LAW
& POLICY INNOVATION
Harvard Law School

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Following our work with Community Servings, we began to deepen our connections to the broader food and nutrition services community, and to research potential sustainable funding streams and integration opportunities for food and nutrition services on a national level. With assistance from the M•A•C AIDS Fund, Community Servings (Boston), God's Love We Deliver (New York), Moveable Feast (Baltimore), MANNA (Philadelphia), Project Angel Heart (Denver), Project Open Hand (San Francisco), Project Angel Food (Los Angeles), Heartland Health (Chicago), Mama's Kitchen (San Diego), and many others, we offer this paper as a tool to assist Medically-Tailored Food and Nutrition Providers (MTFNP) in exploring opportunities to support and integrate the critical services they provide into the larger health care infrastructure as a means to improve health outcomes and lower health care costs.

While we recognize that the concept of food is medicine is broad and encompasses a wide spectrum of interventions, it is our ultimate hope that this paper will be one of many that contributes to shifting the current medical paradigm of health care to one that encompasses all aspects of health, including access to healthy, nutritious food.

About The Center for Health Law and Policy Innovation (CHLPI)

The Center for Health Law and Policy Innovation of Harvard Law School (CHLPI) advocates for legal, regulatory, and policy reforms to improve the health of underserved populations, with a focus on the needs of low-income people living with chronic illnesses and disabilities. CHLPI works with consumers, advocates, community-based organizations, health and social services professionals, food providers and producers, government officials, and others to expand access to high-quality health care and nutritious, affordable food; to reduce health disparities; to develop community advocacy capacity; and to promote more equitable, and effective health care and food systems. CHLPI is a clinical teaching program of Harvard Law School and mentors students to become skilled, innovative, and thoughtful practitioners as well as leaders in health, public health, and food law and policy.

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I. Introduction: The Case for Medically-Tailored Food and Nutrition Intervention Services

For critically and chronically ill people, food is medicine. With adequate amounts of nutritious food, people who are sick have a better response to medication, maintain and gain strength, and have improved chances of recovery. Ultimately, access to healthy food leads to improved health outcomes and lower health care costs.

Food is increasingly recognized as a core component of preventive and ameliorative health care. A variety of innovative initiatives aimed at embedding nutrition into medical care are underway, such as efforts by local food banks to package diabetes-appropriate food boxes for pick-up by pre-diabetic clients or pilot programs that empower providers to prescribe fresh produce vouchers for their undernourished patients.¹

While we recognize that the concept of food as medicine is broad and encompasses a wide spectrum of interventions, this paper focuses on the provision of nutritional counseling and the delivery of medically-tailored, home-delivered meals to those with debilitating chronic or acute illnesses. These types of interventions, hereafter known as medically-tailored food and nutrition intervention services or MTFNI, have been proven to dramatically reduce monthly and overall health care costs for high-risk, high-need patient populations.² They also reduce the frequency of hospital admissions and length of hospital stays, and increase the probability that patients will be discharged from the hospital to their homes instead of to acute care facilities.³

For years, the Ryan White HIV/AIDS Program, a discretionary federal program that provides funding for core medical and support services for low-income individuals living with HIV/AIDS, has recognized this important connection between food and health. The Ryan White Program provides reimbursement for “Medical Nutrition Therapy” as a core medical service. It defines this service to include “nutritional supplements provided outside of a primary care visit by a licensed registered dietitian; [that] may include food provided pursuant to a physician’s recommendation and based on a nutritional plan developed by a licensed registered dietitian.”⁴

¹ Presentation Slides: The Bristol-Myers Squibb Foundation Together on Diabetes Initiative, *Strategies and Policy Recommendations for an Equitable Response to the Type 2 Diabetes Epidemic*, Feeding America Diabetes Initiative, Preliminary Results: 6 Month Behavioral and Health Outcomes, <http://www.nmqf.org/presentations/13DoykosPMEtAIJCP1.pdf>; *Wholesome Wave’s Fruit and Vegetable Prescription Program to Launch in New York City Hospitals*. www.wholesomewave.org, <http://wholesomewave.org/fvrxlaunchinnychospitals/> (last visited September 9, 2013).

² Jill Gurvey, Kelly Rand, Susan Daugherty, Cyndi Dinger, Joan Schmeling, and Nicole Laverty, *Examining Health Care Costs Among MANNA Clients and a Comparison Group*, *Journal of Primary Care & Community Health* (June 2013), 4-5.

³ *Id.*

⁴ HIV/AIDS BUREAU, DIVISION OF METROPOLITAN HIV/AIDS PROGRAMS, *National Monitoring Standards for Ryan White* (2013), available at <http://hab.hrsa.gov/manageyourgrant/files/programmonitoringparta.pdf>.

These services are often provided by community-based organizations, many of which were developed in response to the growing need for nutrition support within the HIV community and rely exclusively on Ryan White Program funding. These community-based organizations and the services they provide are an integral part of the larger, whole-person model of care for HIV that has been developed through the Ryan White Program. This model has helped transform HIV/AIDS from a deadly disease to a chronic illness. Recognizing the potential for food and nutrition interventions to improve health outcomes for other disease populations, some organizations which have relied on Ryan White funds have been able to expand their services over the years to include individuals living with other chronic and critical illnesses.

Organizations that provide MTFNI to clients with debilitating illness (whether HIV or another condition), hereafter known as Medically-Tailored Food and Nutrition Providers or MTFNPs, play a crucial role in keeping medically vulnerable people healthy and at home in their communities. Their services respond to the fact that people with acute and chronic illnesses often have difficulty obtaining and preparing adequate food. Malnourished patients are twice as likely to be readmitted to a hospital within 15 days of discharge and have a much higher risk of death than patients who are well-nourished.⁵ With such high stakes and the potential for significant health benefits and cost savings, it is imperative to advocate for full integration of MTFNI into health care delivery systems.

This paper explores opportunities for MTFNPs to broaden their client base and seek reimbursement for their services in the public and private health care systems, both as these systems exist currently and as they continue to evolve according to the requirements of the Patient Protection and Affordable Care Act (ACA). It begins by explaining how MTFNPs are different from other meal-delivery programs, and why the medical nutrition expertise of MTFNPs uniquely positions them to provide services to people with distinct health conditions and nutritional needs. It then discusses common issues that MTFNPs will need to address as they seek to maximize their funding streams through health insurance reimbursement for services. Ultimately, this paper provides a five-section overview of opportunities for MTFNPs in different public and private insurance structures.

- In Section A, we discuss opportunities for increased integration of MTFNI and reimbursement for services under current and future iterations of Medicaid. We also look at a new coordinated care model created by the ACA, Medicaid Health Homes, and address its implications for coverage of MTFNI.
- In Section B, we examine opportunities under Medicare and a new coordinated care model for Medicare recipients, the Accountable Care Organization.

⁵ Su Lin Kim, Kian Chung Benjamin Ong, Yiong Huak Chan, Wai Chiong Loke, Maree Ferguson, and Lynne Daniels, *Malnutrition and its impact on cost of hospitalization, length of stay, readmission, and 3-year mortality*, Clinical Nutrition (June 1, 2012), Vol. 31, no. 3 pp.345-50.

- In Section C, we discuss programs for people who are dually eligible for both Medicare and Medicaid, including the Program of All-Inclusive Care for the Elderly (PACE) and Integrated Care Organizations (ICOs).
- In Section D, we identify opportunities for MTFNPs to be part of innovative demonstration projects funded by the Center for Medicare and Medicaid Innovation.
- Finally, in Section E, we address opportunities to contract with private health insurers and advocate for strong federal and state support of MTFNI in the private insurance marketplace.

We also include an appendix summarizing government food support programs that may provide other sources of funding for MTFNPs, including the Supplemental Nutrition Assistance Program (SNAP), Title III of the Older Americans Act, the Child and Adult Care Food Program (CACFP), and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

In each section, we discuss the potential for reimbursement of two services typically provided by MTFNPs: nutrition counseling and the provision of home-delivered meals. With a rapidly changing health care landscape focused on cost-saving and innovative delivery models, opportunities for reimbursement of home-delivered meal services coupled with nutritional counseling are likely to grow.

We understand that providing medically-tailored food and nutrition intervention services to critically and chronically ill individuals is just one example of how food acts as medicine. Access to healthy food over the course of a lifetime can entirely prevent people from developing debilitating and devastating illness. This paper is the first segment in the Center for Health Law & Policy Innovation's larger exploration of food as a central and fundamental building block of health. Identifying existing opportunities for integration and reimbursement of medically-tailored food and nutrition intervention services for critically and chronically ill individuals is an important first step in promoting greater recognition and understanding of all food and nutrition services as critical components of health.

Medically-Tailored Food and Nutrition Intervention Providers (MTFNPs): Why They Are Unique Among Meal-Delivery Programs

This paper uses the term MTFNP to refer to organizations that provide home-delivered meals that are nutritionally appropriate for specific medical needs. MTFNPs include but are not limited to organizations such as Community Servings in Massachusetts, God's Love We Deliver in New York, and MANNA in Philadelphia, which all provide home-delivered frozen meals that are both medically and culturally tailored to meet the individual needs of the health-compromised client. At Community Servings, for example, a registered dietitian meets with every new client to assess the client's nutritional needs and prescribe a meal plan customized

to the client's particular illness.⁶ God's Love We Deliver provides illness-specific nutrition education and counseling to clients, along with their families and care providers.⁷ MANNA's clients can meet with a registered dietitian at MANNA's office or at any of their partner organizations in the greater Philadelphia community.⁸ The emphasis on meeting each client's unique medical-nutritional needs with high-quality meals and nutritional counseling distinguishes MTFNPs from other meal-delivery programs. MTFNPs help their clients access a healthy and varied diet of quality foods that are appropriate for their health conditions, medications, and cultural and religious requirements and preferences, so that they may heal and thrive.

Key Considerations in Expansion of Service Reimbursement for MTFNPs

Because many MTFNPs developed in response to the HIV/AIDS epidemic, they have traditionally been reliant on the Ryan White Program for their major source of funding. As these programs grow, it is critical to identify opportunities for more sustainable sources of funding that are not based on discretionary appropriations and grants. Diversification of funding will expand access to these needed services to individuals outside the HIV community, and will help integrate MTFNI services into the larger health care delivery infrastructure. Opportunities for such reimbursement, expansion, and integration exist in both public and private health care programs. Regardless of the opportunities MTFNPs ultimately choose to pursue, three issues will be common to all efforts at integration and expansion. These include: first, assessing and navigating the increased administrative burden associated with securing reimbursement for services from new funding sources and third-party billing; second, investing time and human capital in developing knowledge of complex health care delivery structures and building relationships with key government officials, medical providers, and private insurers; and third, obtaining data that demonstrate the efficacy of the interventions offered by MTFNPs and using that data to advocate for medical nutrition therapy and medically-tailored, home-delivered meals as core components of cost-effective, outcome-driven health care.

1. Assessing and Navigating the Administrative Burden of Third-Party Reimbursement and Potential Changes in Program Delivery Models

New sources of funding often bring increased reporting and documentation requirements. In order to determine whether they can utilize health care coverage to reimburse the services they provide, MTFNPs must assess the insurance status and eligibility for reimbursement of

⁶ Community Servings, *About Us: Our Mission* available at <http://www.servings.org/about/index.cfm> (last visited Dec. 1, 2013).

⁷ God's Love We Deliver, *About Us: Our Mission*, available at <https://www.glwd.org/about/mission.jsp> (last visited Dec. 1, 2013).

⁸ MANNA, *Counseling*, available at <http://www.mannapa.org/nutrition/counseling/> (last visited Dec. 1, 2013).

current and future clients. They must also weigh the cost in staff time and necessary investments in client billing and record-keeping infrastructure required by third-party billing.

In addition, third-party reimbursement may require changes or flexibility in program delivery. For example, some insurers may have rules about how meals must be delivered in order to be eligible for reimbursement, such as requiring a specified number of deliveries per week or delivery within a specified geographic service area or to particular locations. MTFNPs must consider their capacity to meet the requirements of potential partner entities.

2. Building Knowledge of State-Specific Health Care Structures and Relationships with Key Decision-Makers

In order to engage in effective advocacy at the state level, MTFNPs must understand the mix of federal and state agencies and government officials that control the relevant health care programs. Because states are charged with administering many of the programs discussed in this paper and each state also has its own marketplace for private health insurance, the hierarchical structures will vary from state to state. In every state, implementation of the ACA, including the debut of the private health insurance marketplace in October of 2013, is moving at a rapid pace. Some states are also making plans to expand their Medicaid programs in 2014. MTFNPs will need to become familiar with the public insurance and private marketplace administration structures in their states, particularly as many programs and regulations are in a state of fluctuation. Wherever possible, MTFNPs should become active participants in the dialogue surrounding development of these new structures by designating a staff person or staff team to monitor the progress of health reform implementation in their state.

To pursue opportunities with public and private insurance programs and maximize the potential for service referrals from medical providers, MTFNPs will also need to invest time in building relationships with key decision-makers. This might include attending public meetings of health care program working groups, making presentations about their services to public and private insurers, or engaging in outreach to clinics or hospitals that serve a large number of MTFNP clients or potential clients.

3. Using Data to Drive Integration of MTFNI into Health Care

Both public and private insurance programs seek to provide quality health care for the lowest possible cost. MTFNPs are well-positioned to advocate for inclusion in existing and future health care infrastructures. Research has already demonstrated that patients who are nutritionally compromised have worse health outcomes and higher overall health care costs than those who are well-nourished.⁹ The interventions offered by MTFNPs respond to this need for assistance among nutritionally-vulnerable patients. The provision of medically-tailored,

⁹ Su Lin Kim, Kian Chung Benjamin Ong, Yiong Huak Chan, Wai Chiong Loke, Maree Ferguson, and Lynne Daniels, *Malnutrition and its impact on cost of hospitalization, length of stay, readmission, and 3-year mortality*, Clinical Nutrition (June 1, 2012), Vol. 31, no. 3 pp.345-50.

home-delivered meals has been shown to improve health outcomes and dramatically reduce costs.¹⁰

For example, a 2013 study of MANNA's client outcomes showed that monthly health care costs were 31% lower for clients who received the organization's home-delivered meals than for similarly-situated individuals in a comparison group.¹¹ Furthermore, the cost of health care for MANNA clients, all of whom have a serious chronic or acute debilitating illness, decreased by 28% after initiation of MANNA's services.¹² MANNA clients had half the number of hospital admissions as the comparison group, and their length of stay at each visit was 37% shorter than the stays of those who were not receiving MANNA services.¹³ When they were hospitalized, MANNA clients were more likely than individuals in the comparison group to be discharged and able to go back to their homes rather than enter an acute care facility.¹⁴ Broadening the provision of healthy, nutritionally-tailored food as a medical service has the potential to produce significant cost savings and help people stay in their communities. More data and similar studies of other MTFNPs and their clients will strengthen the case for reimbursement and inclusion of MTFNI in routinely-covered core services.

MTFNPs should be prepared to collect and use data to advocate for full integration of their services into health care delivery systems. Framing the intervention they provide in terms of outcomes and savings will open doors to contracts for reimbursement. MTFNPs must begin or continue to track their own outcomes and costs in order to demonstrate the long-term impact of their interventions. At the same time, forming partnerships with health care provider and payment entities may provide MTFNPs with additional resources and infrastructure for quantitative data collection and evaluation.

¹⁰ Jill Gurvey, Kelly Rand, Susan Daugherty, Cyndi Dinger, Joan Schmeling, and Nicole Laverty, *Examining Health Care Costs Among MANNA Clients and a Comparison Group*, Journal of Primary Care & Community Health (June 2013), 4-5.

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

¹⁴ *Id.*

II. Opportunities for Reimbursement and Integration of Medically-Tailored Food and Nutrition Providers with Public and Private Insurance

The following five sections provide an overview of opportunities for MTFNPs to obtain current and future reimbursement-based funding streams from public and private insurance. Each section begins with an overview of the program or insurance landscape and, where relevant, discusses the implications of health reform for each section topic. Each section also describes specific opportunities for reimbursement of MTFNP services and MTFNI integration advocacy.

A. Medicaid

The Medicaid program offers several ways for MTFNPs to receive reimbursement for nutritional counseling (Medical Nutrition Therapy (MNT)) and home-delivered meals. This section looks at coverage of nutritional counseling under existing Medicaid programs and opportunities for increasing coverage through state participation in Medicaid expansion. It examines three additional options states can exercise to expand Medicaid coverage to include home-delivered meals, including the Home and Community-Based Services 1915(c) Waiver, the Home and Community Based Services 1915(i) State Plan Amendment, and the Section 1115 Demonstration Waiver. Some states are already exercising some or all of these options. This section also addresses opportunities to integrate MTFNI into a new Medicaid care delivery model created by the ACA, the Medicaid Health Home.

Medicaid: An Overview

Medicaid is a federal and state-funded health coverage program that provides health insurance to certain categories of low-income individuals. The federal government requires all states who participate in the Medicaid program to provide coverage for all children, pregnant women, parents, elderly, and disabled individuals who meet certain income criteria.¹⁵ To be eligible, individuals must be citizens or immigrants who have had a green card for more than five years. Aside from these basic federal guidelines, states have flexibility in setting eligibility criteria, and every state Medicaid program is different. For example, Alabama provides health coverage to working parents who have incomes below 23% of the Federal Poverty Level (FPL) (23% FPL = about \$5,417 per year for a family of four), while Connecticut covers working parents with

¹⁵ See 42 C.F.R. §§ 435, et seq. (see also KAISER FAM. FOUND., MEDICAID A PRIMER (2013), available at <http://kaiserfamilyfoundation.files.wordpress.com/2010/06/7334-05.pdf>).

incomes up to 191% of FPL (about \$44,981 per year for a family of four).¹⁶ In most states, single adults who are neither parents of dependent children nor disabled are generally excluded from coverage, even if they are extremely low-income and living with a chronic illness.

Every state receives a certain percentage of federal reimbursement (called the Federal Medical Assistance Percentage, or FMAP) for services it provides through its Medicaid program. The federal government, through the Centers for Medicare and Medicaid Services (CMS), sets overall program requirements, and mandates that all states cover certain categories of benefits such as physician services and hospitalizations. States must also follow comparability and state-wideness requirements. This means that states must provide all benefits to all beneficiaries when medically necessary. Beyond these broad requirements, each state administers its own program and has significant discretion over the type, amount, duration and scope of covered services.

The traditional model for reimbursement of Medicaid services is through “fee-for-service,” meaning that a healthcare provider bills Medicaid for each individual service provided to a client, such as nutritional counseling. However, many states are now contracting with managed care organizations (MCOs) to manage and pay for all or some of their Medicaid benefits. In a managed care model, Medicaid provides fixed per-member per-month (PMPM) payments to an MCO to cover all or some of the state-required services for Medicaid members that belong to the MCO. The MCO bears some of the risk if the services provided exceed the costs of the capitation, but can also be rewarded if costs are kept low. The MCO may also choose to cover additional services, either because the MCO believes the benefit to health will outweigh the cost of providing such a service, or as a means of attracting clients. MCOs could choose to cover home-delivered meals for all or some of their critically-ill Medicaid enrollees for these reasons.

Medicaid Coverage of Nutritional Counseling

Under federal Medicaid rules, nutritional counseling is not specifically listed as either a mandated or optional benefit in the Medicaid program as it currently exists.¹⁷ However, because of the broad flexibility given to states in defining benefits, a state can choose to cover nutritional counseling as part of its definition of services under one of the existing categories. For example, states can cover it as part of the mandated category of physician services,¹⁸ or as an optional benefit category like preventive services.¹⁹ States may cover nutritional counseling

¹⁶ *Adult Income Eligibility Limits at Application as a Percent of the Federal Poverty Level (FPL)*, KAISER FAM. FOUND., <http://kff.org/medicaid/state-indicator/income-eligibility-low-income-adults/> (last visited Dec. 1, 2013).

¹⁷ See 42 C.F.R. §§ 440.1, et seq; *Medicaid Benefits*, MEDICAID, <http://medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html> (last visited Dec. 3, 2013).

¹⁸ Physician services are defined broadly under federal law as “services furnished by a physician-- (1) Within the scope of practice of medicine or osteopathy as defined by State law; and (2) By or under the personal supervision of an individual licensed under State law to practice medicine or osteopathy.” 42 C.F.R. § 440.50.

¹⁹ Preventive services are defined as: services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to--(1) prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and

for all beneficiaries or choose to cover nutritional counseling only for certain populations. For example, states may choose to cover nutritional counseling only as part of chronic disease management for individuals living with HIV, diabetes, or for individuals struggling with obesity.

Generally all Medicaid services must be provided by a physician, nurse practitioner or “other licensed practitioner of the healing arts acting within the scope of authorized practice under state law.”²⁰ This means that if a state wants to offer nutritional counseling, it must be provided by a licensed nutritionist, registered dietitian, or by another professional whose licensure encompasses nutrition services, such as a certified diabetes educator. Individual states may have additional rules that apply, such as only covering nutritional counseling services if they are provided in conjunction with a physician or other traditional medical provider. For example, in Massachusetts, MassHealth (Massachusetts’ Medicaid program) generally covers Medical Nutrition Therapy, defined as “nutritional diagnostic therapy and counseling services for . . . management of a medical condition,” if the service is provided by a MassHealth-registered physician, a registered dietitian or a licensed nutritionist.²¹ A registered dietitian or licensed nutritionist cannot receive reimbursement under MassHealth unless she is under the supervision of a physician or another approved MassHealth provider. Because neither registered dietitians nor licensed nutritionists can become MassHealth providers on their own,²² for an MTFNP in Massachusetts to receive Medicaid reimbursement for nutritional counseling services, it must partner with a physician or other approved MassHealth provider. By contrast, registered dietitians in Maryland are able to provide services without physician supervision and bill Medicaid directly for reimbursement once referred by a case manager.²³ Moveable Feast, an MTFNP in Baltimore, bills Medicaid directly (using an assigned agency code) for nutritional counseling services provided to its clients by its dietitians after the client is referred for services by the client’s Medicaid case manager.²⁴

However, recent changes to the definition of “preventive services” under federal law give states more flexibility to allow a broader range of providers, such as community health workers, to offer preventive services, as long as they are provided at the recommendation of a physician

efficiency. 42 C.F.R. § 440.130 (2013); see also KATHLEEN SEBELIUS, REPORT TO CONGRESS: PREVENTIVE AND OBESITY-RELATED SERVICES AVAILABLE TO MEDICAID ENROLLEES 9 (2010), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/RTC_PreventiveandObesityRelatedServices.pdf.

²⁰ See 42 C.F.R. § 440.50 and § 42 C.F.R. 440.130.

²¹ Bulletin from Tom Dehner, Medicaid Director, Massachusetts Office of Medicaid, to Physicians Participating in MassHealth (Jul. 2007).

²² *Id.*; *Information About Massachusetts Insurers*, MASS. DIETETIC ASS’N, <http://www.eatrightma.org/content5664> (last visited Dec. 1, 2013).

²³ See *Medicaid Waiver for Older Adults Billing and Reimbursement Reference Guide*, 14 (April 2011), <http://www.aging.maryland.gov/documents/BillingandReimbursementGuide.pdf> (Note, as will be discussed in latter sections of this paper, Maryland Medicaid only covers nutritional counseling for individuals in its waiver population).

²⁴ E-mail from Thomas Bonderenko, Exec. Dir., Moveable Feast to Duncan Farthing-Nichol, Student, Harvard Law School (Nov. 14, 2012, 12:48 EST) (on file with author); E-mail from Thomas Bonderenko, Exec. Dir., Moveable Feast to Duncan Farthing-Nichol, Student, Harvard Law School (Feb. 3, 2014, 11:13 EST) (on file with author); Interview with Thomas Bonderenko, Exec. Dir., Moveable Feast (Jul. 30, 2013); For more information about Moveable Feast, visit <http://www.mfeast.org/> (last visited Dec. 1, 2013).

or other licensed practitioner.²⁵ Therefore states that choose to offer nutritional counseling as a preventive benefit will have more options in determining who may provide these services.

Medicaid Coverage of Home-Delivered Meals

For most beneficiaries, Medicaid does not provide coverage for home-delivered meals as a health care benefit. There are three routes a state can take to alter or enhance their Medicaid programs in order to make meals reimbursable. These include: (1) a Home and Community-Based Services (HCBS) 1915(c) Waiver;²⁶ (2) a Home and Community-Based Services (HCBS) 1915(i) State Plan Amendment;²⁷ or (3) a Section 1115 Demonstration Waiver.²⁸

(1) HCBS 1915(c) Waivers

The main option through which states cover home-delivered meals is the Section 1915(c) HCBS waiver. A state may use a Medicaid waiver to cover non-traditional services, provide targeted services to specific populations (in other words, waiving the comparability and state-wideness requirements), and/or perform other activities that the federal Medicaid program would otherwise not cover for a limited period of time (usually 3-5 years).²⁹ Section 1915(c) HCBS waivers are a particular type of waiver that support in-home services to help states avoid institutionalizing individuals who would otherwise need to be placed in a nursing home.³⁰ The main target populations for HCBS waiver services are seniors, people with physical and intellectual disabilities, and people with mental illnesses. States can also choose to target HCBS waiver services more narrowly. For instance, a state could obtain an HCBS waiver to provide HCBS benefits to individuals living with HIV/AIDS. While federal law delineates certain specified benefits that states may cover as part of HCBS, it also permits states to request additional

²⁵ Previously, preventive services were defined as: services *provided* by, (as opposed to the new *recommended* by), a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to--(1) prevent disease, disability, and other health conditions or their progression; (2) Prolong life; and (3) Promote physical and mental health and efficiency. 42 C.F.R. § 440.130 (2012).

²⁶ See 42 C.F.R. §§ 441.300, et seq.; *Home and Community Based 1915(c) Waivers*, MEDICAID, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html> (last visited Dec. 1, 2013).

²⁷ 42 U.S.C. § 1396n(i); see CTRS. FOR MEDICARE & MEDICAID SERVS. *Re: Improving Access To Home and Community Based Services* 8 (Aug. 6, 2010), http://www.healthreformgps.org/wp-content/uploads/he08092010_waiver.pdf.

²⁸ See 42 C.F.R. §§ 431.400, et seq.; *Section 1115 Demonstrations*, MEDICAID, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html> (last visited Dec. 1, 2013).

²⁹ *Waivers*, MEDICAID, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html> (last visited Dec 1, 2013, 2013). See also FAMILIES USA, ISSUE BRIEF, STATE PLAN AMENDMENTS AND WAIVERS: HOW STATES CAN CHANGE THEIR MEDICAID PROGRAMS (2012), *available at* <http://familiesusa2.org/assets/pdfs/medicaid/State-Plan-Amendments-and-Waivers.pdf>.

³⁰ See 42 C.F.R. §§ 441.300 Et seq.; *Home and Community Based 1915(c) Waivers*, MEDICAID, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Home-and-Community-Based-1915-c-Waivers.html> (last visited Dec. 1, 2013).

services as may be approved by CMS, and home-delivered meals have been allowed under this category.³¹

To be eligible for HCBS waiver services, federal law requires that an individual meet the state's income and other financial requirements, and that but for the provision of home and community-based services, the individual would otherwise meet the state's criteria for needing to be institutionalized in a nursing facility, hospital or intermediate care facility for individuals with intellectual disabilities.³² In order to be granted an HCBS waiver, states must demonstrate that the cost of providing HCBS would not exceed the cost of services for the target population in an institution.³³

Each state has a different mix of HCBS 1915(c) waivers, each with different target populations, benefits, and eligibility criteria, including different criteria for institutionalization. In Massachusetts for example, the Frail Elder HCBS 1915(c) waiver covers nutritional counseling and home-delivered meals, among other services, for people who are age 60 or over, meet certain financial criteria, and require a nursing facility level of care or higher.³⁴ In Massachusetts, a person meets the nursing facility level of care if she:

- a) needs at least one skilled nursing or therapist service daily or
- b) needs nursing services at least three times per week, plus two other services per week which can include either additional nursing services or assistance with daily living services, or a combination of the two.³⁵

By contrast, in Maryland, older individuals are eligible for HCBS waiver services if it is determined that they need "nursing facility services,"³⁶ defined as "services provided to individuals who do not require hospital care, but who, because of their mental or physical condition, require skilled nursing care and related services, rehabilitation services, or, on a regular basis, health-related care and services (above the level of room and board) which can be made available to them only through institutional facilities."³⁷

In addition, states vary in how these HCBS waivers are administered. In many states, there is a coordinating agency which oversees eligibility, enrollment, and care plan creation. As with

³¹ 42 C.F.R. §§ 440.180(b)(9).

³² 42 C.F.R. §§ 441.302(c).

³³ 42 C.F.R. §§ 441.302 (e); For more information on waiver requirements versus other types of state changes to Medicaid programs, see FAMILIES USA, ISSUE BRIEF, STATE PLAN AMENDMENTS AND WAIVERS: HOW STATES CAN CHANGE THEIR MEDICAID PROGRAMS (2012), available at <http://familiesusa2.org/assets/pdfs/medicaid/State-Plan-Amendments-and-Waivers.pdf>.

³⁴ 130 C.M.R. § 519.007; see also *Home and Community-Based Service Waiver (HCBS)*, MASSRESOURCES.ORG, <http://www.massresources.org/masshealth-waiver.html#frailelder> (last visited Dec. 1, 2013); Home-delivered meals provided under the Waiver must "comply with the Executive Office of Elder Affairs' Nutrition Standards, and be religiously and ethnically appropriate to the extent feasible." E-mail from Shirley Wong, MassHealth, to Duncan Farthing-Nichol, Student, Harvard Law School (Dec. 3, 2012, 13:05 EST) (on file with author).

³⁵ 130 C.M.R. § 456.409; see also *Home and Community-Based Service Waiver (HCBS)*, MASSRESOURCES.ORG, <http://www.massresources.org/masshealth-waiver.html#frailelder> (last visited Dec. 1, 2013).

³⁶ COMAR 10.09.10.01(B)(41).

³⁷ COMAR 10.09.55.03(C)(1).

other Medicaid programs, states may offer their HCBS waiver services through traditional fee-for-service programs or through managed care organizations (MCOs). Other states offer a hybrid of the two. For example, in Massachusetts, Aging Services Access Points (ASAPs) administer all Frail Elder Waiver services in the state,³⁸ and reimbursement includes both a traditional fee-for-service option and a managed care option.³⁹

In some instances, MTFNPs may be able to contract with the state directly to provide home-delivered meals services. In Maryland, the Living at Home 1915(c) waiver allows physically-disabled individuals ages 18-64 to receive a range of services, including nutrition services and home-delivered meals.⁴⁰ The state's Older Adults waiver includes nutritional services and home-delivered meals among the services Medicaid provides for individuals 65 and older.⁴¹ Moveable Feast, an MTFNP in Maryland, responded to a state Request For Proposal (RFP) to provide home-delivered meal services to individuals covered by these waivers.⁴² Moveable Feast was selected by the state as a vendor, and now provides services for eligible individuals at a reimbursement rate that is determined by the state. Moveable Feast does not assess qualifications for HCBS among their clients, but instead receives referrals for MNT and/or home-delivered meals from case managers who coordinate waiver services for individuals already enrolled in HCBS. Once Moveable Feast receives a referral for a service, they provide MNT by a registered dietitian and/or home-delivered meals, and then bill the state directly (note that not all clients receive both interventions, and therefore billing is separate for each service).⁴³

In states offering long-term managed care, it may be possible for MTFNPs to negotiate directly with MCOs. For example, God's Love We Deliver (God's Love), an MTFNP in New York City, receives Medicaid reimbursement through contracts with Managed Long-Term Care (MLTC)

³⁸651 C.M.R. § 14.03(8).

³⁹Eligibility Operations Memo 10-10, from Russ Kulp, Director, MassHealth Operations, Massachusetts Office of Medicaid, to MassHealth Eligibility Operations Staff, (Jun. 15, 2010), *available at*: <http://www.mass.gov/eohhs/docs/masshealth/eom2010/eom-10-10.pdf>.

⁴⁰ *MD Living at Home Waiver*, 0353.R02.00, *Waivers*, *available at*: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=maryland>; *see also Living at Home Waiver*, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE (2010), *available at* https://mmcp.dhmdh.maryland.gov/docs/Living_Home_Waiver_Fact_Sheet_October_2010.pdf.

⁴¹ *MD Older Adults Waiver*, 0265.R04.00, *available at*: <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html?filterBy=maryland>; *see also, Older Adults Waiver*, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE (2010), *available at*: https://mmcp.dhmdh.maryland.gov/docs/Living_Home_Waiver_Fact_Sheet_October_2010.pdf.

⁴² E-mail from Thomas Bonderenko, Exec. Dir., Moveable Feast to Duncan Farthing-Nichol, Student, Harvard Law School (Nov. 14, 2012, 12:48 EST) (on file with author); Interview with Thomas Bonderenko, Exec. Dir., Moveable Feast (Jul. 30, 2013); For more information about Moveable Feast, visit <http://www.mfeast.org/> (last visited Dec. 1, 2013).

⁴³ *Id.*; E-mail from Thomas Bonderenko, Exec. Dir., Moveable Feast to Duncan Farthing-Nichol, Student, Harvard Law School (Feb. 3, 2014, 11:13 EST) (on file with author); Interview with Thomas Bonderenko, Exec. Dir., Moveable Feast (Jul. 30, 2013); For more information about Moveable Feast, visit <http://www.mfeast.org/> (last visited Dec. 1, 2013).

plans.⁴⁴ MLTC plans are MCOs paid a capitated rate by New York Medicaid to provide comprehensive health services to a long-term care population.⁴⁵ God's Love negotiates directly with the MLTC plan and the plan then pays God's Love the cost for the nutritional counseling and/or home-delivered meals provided to the client. While nutritional counseling is required for all clients, some MLTC plans provide their own nutritional counseling services separate from God's Love. In such cases, the reimbursement for the client covers only the cost of the meals.

(2) HCBS 1915(i) State Plan Amendment

In addition to the HCBS waiver, states can also offer home and community based services through an HCBS 1915(i) State Plan Amendment to individuals with incomes below 150% FPL who need assistance with care but are not yet at a level requiring institutionalization (as is required for HCBS waivers).⁴⁶ Prior to the ACA, the types of services states could provide under this option were more limited than those under HCBS waivers, and could not be targeted to specific populations. However, the ACA makes several changes to the 1915(i) option in order to make it more attractive to states.⁴⁷ First, it allows states to offer the full range of HCBS waiver services, including benefits such as home-delivered meals, that CMS may approve. Second, as with the HCBS waiver, benefits can now be targeted to specific populations, such as individuals living with HIV/AIDS or other chronic illnesses. Third, the ACA gives states the option to create a separate Medicaid eligibility category for individuals eligible for 1915(i) services (i.e., individuals do not have to meet an additional Medicaid eligibility requirement, such as being disabled, or the parent of a child). Finally, it allows states to expand eligibility for HCBS 1915(i) services to individuals who meet the eligibility criteria for HCBS waiver services with incomes up to 300% of the Supplemental Security Income (SSI) benefit rate.

Generally, a 1915(i) State Plan Amendment is a permanent change to the Medicaid program, where the 1915(c) waiver comes with the administrative burden of having to be periodically renewed.⁴⁸ However, when the 1915(i) option is used to provide services to targeted

⁴⁴ Interview with Alissa Wassung, Executive Policy and Planning Associate, God's Love We Deliver, in New York, NY (Nov. 15, 2012). Note that New York actually provides these home and community based services through a different kind of waiver, the 1115 Demonstration waiver, discussed later in the paper). E-mail from Alissa Wassung, Executive Policy and Planning Associate, God's Love We Deliver to author (Aug. 26, 2013, 1:23 EST) (on file with author).

⁴⁵ *Id.*

⁴⁶ 42 U.S.C. § 1396n(i).

⁴⁷ See CTRS. FOR MEDICARE & MEDICAID SERVS., *Re: Improving Access To Home and Community Based Services* 8 (Aug. 6, 2010), available at http://www.healthreformgps.org/wp-content/uploads/he08092010_waiver.pdf; SARAH SOMERS, NATIONAL HEALTH LAW PROGRAM, COVERING HCB SERVICES THROUGH THE 1915(i) STATE PLAN OPTION STATE (NATIONAL) (Nov. 23, 2010) available at <http://www.healthlaw.org/issues/medicaid/medicaid-expansion-toolbox/state-resources/qa-covering-hcb-services-through-1915i-state-plan-option>; see also KAISER FAM. FOUND., STATE OPTIONS THAT EXPAND ACCESS TO MEDICAID HOME AND COMMUNITY-BASED SERVICES (2011), available at <http://www.kff.org/medicaid/upload/8241.pdf>; DAVID MACHLEDT, NATIONAL HEALTH LAW PROGRAM, PROMOTING COMMUNITY LIVING: UPDATES ON HCBS & THE ACA 5 (2012), available at http://healthlaw.org/images/stories/Promoting_Community_Living_Updates_on_HCBS_&_the_ACA.pdf.

⁴⁸ KAISER FAM. FOUND., STATE OPTIONS THAT EXPAND ACCESS TO MEDICAID HOME AND COMMUNITY-BASED SERVICES (2011), available at <http://www.kff.org/medicaid/upload/8241.pdf>; DAVID MACHLEDT, NATIONAL HEALTH LAW PROGRAM,

populations, the option must be renewed at the end of five years. There is flexibility in the type of targeted services that can be provided through a 1915(i) State Plan Amendment. For example, Montana recently proposed an amendment to provide certain mental health services (such as peer support and home-based therapy) to youth with serious emotional disturbances.⁴⁹ No state has requested a 1915(i) State Plan Amendment in order to specifically cover home-delivered meals or nutritional counseling. However, the ability to make a change that targets specific services to populations who may not yet need to be institutionalized makes the 1915(i) State Plan Amendment an important option for expanding state Medicaid coverage of home-delivered meals. In addition, unlike the option to change Medicaid through a waiver, there is no requirement to demonstrate cost or budget neutrality.

(3) Section 1115 Demonstration Waiver

In addition to waivers and state plan amendments that are specific to HCBS services, states also have the option to apply for section 1115 demonstration waivers.⁵⁰ Section 1115 demonstration waivers are designed to give states broad options to expand eligibility, offer different kinds of benefits, and experiment with various care delivery models in order to improve Medicaid programs. These waivers must be budget neutral, meaning that a state must demonstrate that the changes they are requesting would not require any more federal dollars over the course of the project than what would have been the case if the state had not enacted the waiver.⁵¹ Massachusetts, for example, has an 1115 waiver that expands Medicaid eligibility

PROMOTING COMMUNITY LIVING: UPDATES ON HCBS & THE ACA 5 (2012), *available at* http://healthlaw.org/images/stories/Promoting_Community_Living_Updates_on_HCBS_&_the_ACA.pdf. For a more detailed explanation of the administrative requirements for waivers compared to state plan amendments (i.e., making a change to the state's overall Medicaid program rather than asking the federal government to temporarily waive certain requirements), see FAMILIES USA, ISSUE BRIEF, STATE PLAN AMENDMENTS AND WAIVERS: HOW STATES CAN CHANGE THEIR MEDICAID PROGRAMS (2012), *available at* <http://familiesusa2.org/assets/pdfs/medicaid/State-Plan-Amendments-and-Waivers.pdf>.

⁴⁹ 1915(i) Home and Community Based Services State Plan Program For Youth With Serious Emotional Disturbance (2013), MONTANA DEP. OF HEALTH AND HUMAN SERVS., *available at* <http://www.dphhs.mt.gov/mentalhealth/children/i-home/PolicyManual.pdf>.

⁵⁰ See 42 C.F.R. §§ 431.400, et seq.; *Section 1115 Demonstrations*, MEDICAID, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html> (last visited Dec. 1, 2013); ROBIN RUDOWITZ, ET AL., KAISER FAM. FOUND., A LOOK AT MEDICAID 1115 DEMONSTRATION WAIVERS UNDER THE ACA: A FOCUS ON CHILDLESS ADULTS (Oct. 9, 2013), *available at*: <http://kff.org/report-section/section-1115-medicaid-demonstration-waivers-issue-brief/>.

⁵¹ Calculations for budget neutrality can be complex and varies by state. Generally cost-neutrality is enforced through use of capped funds: the federal government will agree to expend only a certain amount of money through the duration of the waiver, with the state at risk for expenditures beyond that amount. For more information, see ROBIN RUDOWITZ, ET AL., KAISER FAM. FOUND., A LOOK AT MEDICAID 1115 DEMONSTRATION WAIVERS UNDER THE ACA: A FOCUS ON CHILDLESS ADULTS, (Appendix A) (Oct. 9, 2013), *available at*: <http://kff.org/report-section/section-1115-medicaid-demonstration-waivers-appendix/>; THE ROBERT WOOD JOHNSON FOUND., STATE COVERAGE INITIATIVES ISSUE BRIEF, MEDICAID 1115 WAIVERS AND BUDGET NEUTRALITY: USING MEDICAID FUNDS TO EXPAND COVERAGE (May 2001), *available at* <http://www.statecoverage.org/files/Section%201115%20Waivers%20and%20Budget%20Neutrality%20-%20Using%20Medicaid%20Funds.pdf>; U.S. GOV'T ACCOUNTABILITY OFFICE, MEDICAID DEMONSTRATION WAIVERS APPROVAL PROCESS RAISES COST CONCERNS AND LACKS TRANSPARENCY (Jun. 2013) *available at*:

for all individuals living with HIV/AIDS in the state with income below 200% FPL (\$22,980/year for an individual), among other initiatives.⁵² Some states, like New York, use 1115 waivers to provide HCBS services. States could also use an 1115 waiver to offer home-delivered meals as part of a benefits package for certain individuals. For example, a state might apply for an 1115 waiver to expand coverage to individuals with certain chronic illnesses, such as HIV/AIDS or diabetes, and include home-delivered meals among the benefits offered. As an alternative to pushing for a change that covers the whole population, advocates can frame the 1115 waiver as a way for their state to test the efficacy of providing MTFNI to certain populations in order to decrease costs and improve health outcomes. Like the HCBS state plan option, the 1115 waiver is another means for covering meals through Medicaid that advocates could urge their states to pursue.

*Medicaid and the ACA*⁵³

Prior to the ACA, in most states individuals had to be both low-income and meet a particular category of eligibility (e.g., by being either a parent of a child or by being disabled) in order to qualify for Medicaid. Beginning in 2014, the ACA gives states the option to eliminate categorical eligibility requirements and expand their Medicaid programs to all individuals with incomes below 133% FPL (about \$15,282 year for a single person in 2013), meaning that most individuals will be eligible for Medicaid so long as they meet the income standards. The law as originally passed required all states to participate in this expansion, but due to a Supreme Court decision in July of 2012, expanding Medicaid is now optional for states.⁵⁴ There is no deadline by which states must decide whether to expand Medicaid, but there are financial incentives in the form of increased federal reimbursement rates for states that expand their Medicaid programs prior to 2020.

Newly eligible Medicaid beneficiaries under the ACA expansion must have access to health plans that cover at least ten categories of services, called Essential Health Benefits or EHBs.⁵⁵

<http://www.gao.gov/assets/660/655483.pdf>. For additional information on 1115 waivers and cost-offsets for HIV populations, see HARVARD LAW SCHOOL HEALTH LAW AND POLICY CLINIC, TREATMENT ACCESS EXPANSION PROJECT, AND AIDS FOUNDATION OF CHICAGO, 1115 WAIVERS: A BRIDGE TO 2014 FOR PEOPLE LIVING WITH HIV (Nov. 2010), available at:

<http://www.taepusa.org/Library/PowerpointPresentations.aspx>

⁵² See *Massachusetts Section 1115 Demonstration Factsheet* (Sept. 11, 2013), MEDICAID, available at <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/ma-masshealth-fs.pdf>.

⁵³ For a comprehensive summary of the Affordable Care Act, see KAISER. FAM. FOUND., FOCUS ON HEALTH REFORM: SUMMARY OF THE AFFORDABLE CARE ACT, P.L. 111-148, (April 23, 2013) available at <http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf>.

⁵⁴ *National Federation of Independent Business v. Sebelius*, 132 S.Ct. 2556 (2012).

⁵⁵ 42 C.F.R. § 440.347; Essential Health Benefits include items and services within 10 categories including: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care; see also *Glossary: Essential Health Benefits*, WWW.HEALTHCARE.GOV,, <https://www.healthcare.gov/glossary/essential-health-benefits/> (last visited Dec. 3, 2013).

These ten categories include, among other benefits, both preventive care and chronic disease management. As part of the EHB package, benefits packages must include coverage without cost-sharing of all preventive health services that receive an “A” or “B” rating from the United States Preventive Services Task Force (USPSTF).⁵⁶ This has particular implications for Medicaid coverage of nutritional counseling, referred to in many Medicaid programs as medical nutrition therapy. While general nutritional counseling for all populations has not yet been given an A or B rating, the USPSTF does give a “B” rating to nutritional counseling “for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.”⁵⁷ This means that all Medicaid plans for the newly eligible beneficiaries must cover MNT at least at the level recommended by the USPSTF.

Beyond covering specified USPSTF preventive services, there are very few specific service requirements for EHB categories.⁵⁸ Initially, advocates had hoped that EHB mandates would present an opportunity to set a comprehensive federal floor of required coverage. However, since the passage of the ACA, the federal government has decided that each state will be responsible for defining its own EHB package by reference to a chosen “benchmark” plan. In Medicaid, health plans for newly eligible individuals are called Alternative Benefits Plans (ABPs). States must create an ABP package from a prescribed set of benchmark plans (including the state’s existing Medicaid package) or may create their own ABP with federal government approval.⁵⁹ All ABPs must cover all ten EHB categories, including USPSTF A and B recommended services. States could choose to include coverage of home-delivered meals and nutritional counseling in their APBs for all their newly eligible beneficiaries who need these services, though they are not mandated to do so. States also have the opportunity to create more than one ABP for different populations, and vary the types of services each ABP covers. For example, states could create a separate ABP for newly eligible individuals living with HIV, cancer or other chronic illness that includes coverage of home-delivered meals. Regardless of how many different ABPs a state creates, each package must include coverage of all EHB categories.

Since many states have not yet selected their ABPs and states have the authority to create new ABPs, there is still time for MTFNPs in Medicaid expansion states to advocate for inclusion of nutritional counseling and home-delivered meals. In order to expand Medicaid, each state must submit an amendment to their Medicaid state plans to the federal government describing their new ABPs. Prior to initiating this amendment, states will need to provide advance notice to the public and a “reasonable opportunity” for comment.⁶⁰ Note that some states have also begun

⁵⁶ See *Glossary: What Are My Preventive Care Benefits*, [WWW.HEALTHCARE.GOV](http://www.healthcare.gov/what-are-my-preventive-care-benefits/), <https://www.healthcare.gov/what-are-my-preventive-care-benefits/> (last visited Dec. 1, 2013).

⁵⁷ *USPSTF A and B Recommendations*, UNITED STATES PREVENTIVE SERVICES TASK FORCE, <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm> (last visited Dec. 1, 2013).

⁵⁸ For a list of United States Preventive Services Task Force (USPSTF) A and B Recommendations, see *USPSTF A and B Recommendations*, UNITED STATES PREVENTIVE SERVICES TASKFORCE, <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm> (last visited Dec. 1, 2013).

⁵⁹ 42 C.F.R. § 440.300, et seq.; see also *Frequently Asked Questions on Essential Health Benefits Bulletin*, (Nov. 16, 2011), CTRS. FOR MEDICARE & MEDICAID SERVS. *available at* <http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf>.

⁶⁰ 42 C.F.R. §440.386 (new as of July 2013).

to use 1115 Medicaid waivers to implement their expansion programs rather than a state plan amendment.⁶¹ The 1115 waiver process also requires opportunities for public comment. In this context the opportunity for comment must be at least 30 days and the state must hold a minimum of two public hearings.⁶² MTFNPs should participate in any public comment periods and/or hearings to advocate for inclusion of their services.

Even prior to the public comment period, MTFNPs should also consider joining coalitions of advocates for the chronically ill to collectively urge their state to cover medically-tailored food and nutrition intervention services for all newly eligible beneficiaries or, in the alternative, to develop different ABPs for these populations. ABPs for the chronically ill could include nutritional counseling, home-delivered meals, more expansive case management, and other benefits that are particularly critical to this population.

However, it is important to note that under the ACA, newly eligible and existing Medicaid beneficiaries might be treated differently when it comes to coverage of preventive services like nutritional counseling.⁶³ For the existing Medicaid population, in both expansion and non-expansion states, the state is not required to make any changes to the current level of benefits or cost-sharing. The federal government has tried to incentivize states to voluntarily cover preventive services recommended by the USPSTF without cost-sharing for their existing population, by increasing their Federal Medical Assistance Percentage (FMAP) funds by 1% if they do, but this is not required.⁶⁴ Therefore, after Medicaid expands, some individuals within the same state with similar medical profiles may not be entitled to receive the same services at the same cost-sharing levels, even though they are both enrolled in the state's Medicaid program.

New Coordinated Care Options for Medicaid: Medicaid Health Homes (MHH)

In addition to expanding eligibility, the ACA creates the Medicaid Health Home option, a new opportunity for states to provide additional care coordination and support services to individuals on Medicaid who are living with chronic illnesses. Medicaid Health Homes (MHH) build on the concept of the Patient-Centered Medical Home (PCMH) model of care, which emphasizes coordinated and holistic primary care services for patients as overseen by a

⁶¹ States that are using this process are usually opting for waivers because they are requesting permission to expand Medicaid in the form of premium assistance for private plans rather than through the creation of new Alternative Benefit Plans (ABPs) in their existing Medicaid programs. In this model, the state instead uses Medicaid dollars to help newly eligible enrollees purchase qualified health plans (QHPs) on the new private health insurance marketplaces. See, for example, THE ARKANSAS HEALTH CARE INDEPENDENCE PROGRAM (PRIVATE OPTION)-DEMONSTRATION, (Sept. 27, 2013) *available at* <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ar/ar-private-option-ca.pdf>.

⁶² 42 CFR § 431.412.

⁶³ *Existing Medicaid Beneficiaries Left Off the Affordable Care Act's Prevention Bandwagon*, Sara E. Wilensky and Elizabeth A. Gray, *Health Affairs* 32 No. 7 (2013), 1188-1195.

⁶⁴ SARA ROSENBAUM, HEALTHREFORMGPS, UPDATE: MEDICAID PREVENTIVE SERVICES COVERAGE INCENTIVE FOR TRADITIONAL ADULT BENEFICIARIES COVERED UNDER THE STANDARD MEDICAID PROGRAM (Feb., 21, 2013), *available at* <http://healthreformgps.org/wp-content/uploads/Rosenbaum-Medicaid-Prevention-Incentive-SMD.pdf>.

particular provider or group of providers. Many Medicaid programs (like MassHealth in Massachusetts, for example) and/or private MCOs are likely to require most enrollees to get their primary care from a PCMH in the future.

The MHH option is a formal Patient-Centered Medical Home for Medicaid recipients living with two or more specified chronic health conditions, or who have a specified chronic condition and are considered to be at risk for another. MHHs have a particular emphasis on providing integrated behavioral health services, meaning that MHHs must have a plan to ensure access to coordinated primary care, mental health, and substance-use disorder services. States that take up the MHH option receive increased federal matching dollars for the provision of MHH care coordination services.⁶⁵ These services must at least include: comprehensive care management and coordination; health promotion; comprehensive transitional care and follow-up; incorporation of patient and family support; and referral to community and social support services. Any state can create MHHs regardless of whether the state participates in the Medicaid expansion.⁶⁶

MHH providers are expected to coordinate all aspects of a patient's health, including chronic disease management, and must help to connect the patient with outside community social supports as needed. States have the option of allowing three different types of entities to serve as an MHH: 1) a designated provider, such as physician or health center; 2) a team of health professionals, which may include a nutritionist; or 3) a health team, which must include a nutritionist, among other providers.⁶⁷ Although states have discretion in whether and how to offer MHHs, the law's specific mention of nutritionists in two types of provider categories indicates that nutrition services should be part of care delivery, management, and coordination in all MHHs. Moreover, MHHs need to meet specific quality metrics. CMS has suggested that such metrics include documentation of the number of enrollees who receive an Adult Body Mass Index (BMI) assessment and reduced acute inpatient readmission, both of which can be improved by access to nutrition services and/or home-delivered meals.⁶⁸ The MHH's focus on comprehensive, holistic, and cost-effective care for chronically ill individuals aligns with the mission and client population served by MTFNPs, creating an important opportunity for partnership and integration.

⁶⁵ *Health Homes*, MEDICAID, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html> (last visited Dec. 1, 2013).

⁶⁶ ACA, 42 U.S.C. § 2703 (2010); *see also* CTRS. FOR MEDICARE & MEDICAID SERVS. *Re: Health Homes for Enrollees with Chronic Conditions* 8 (Nov. 16, 2010), available at <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf>.

⁶⁷ ACA, 42 U.S.C. § 2703(a) (2010).

⁶⁸ CTRS. FOR MEDICARE & MEDICAID SERVS. *Re: Health Homes Core Quality Measures* (Jan. 15, 2013), available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-001.pdf>.

Opportunities for Medicaid Advocacy

In traditional Medicaid, any coverage of nutrition services, including home-delivered meals and nutritional counseling, is optional for states. As a result some states only cover nutritional counseling and/or home-delivered meals on a very limited basis, while others do not cover these services at all. As Medicaid programs expand under the ACA, newly eligible Medicaid beneficiaries will gain access to coverage of nutritional counseling for certain conditions, as defined by the USPSTF, but not all states will choose to expand their programs, and home-delivered meals are not included as part of the newly required services.⁶⁹

MTFNPs could advocate for their state Medicaid programs to begin to cover, or expand existing coverage of, both nutritional counseling and home-delivered meals as part of their current Medicaid benefit plans, and as part of ABPs for newly eligible enrollees in Medicaid expansion states. If states do not already cover these services, this would require a legislative or administrative change, depending on the state. Some states require legislative approval prior to making a change to Medicaid benefits, while others only require administrative approval by the state Medicaid office. In the first instance, state advocates would need to urge passage of a state law that requires the state Medicaid program to cover nutritional counseling and/or home-delivered meals. In other states, advocates may be able to work directly with Medicaid administrative officials to make this change.

In either case, in order to change Medicaid benefits, states must ultimately amend their Medicaid state plans or apply for waivers, and all proposed changes must be approved by the federal government. There are no federal restrictions that prohibit the ability of a state to offer either nutritional counseling or home-delivered meals.⁷⁰ Because of the broad flexibility given to states in defining the amount, duration and scope of offered benefits, it is possible for nutritional counseling or home-delivered meals to be included as a benefit under one of the existing mandatory or optional categories (such as physician services or preventive services), or as a separate CMS-approved benefit. In addition to advocacy at the state level, as will be discussed later in the paper, the federal standards for essential health benefits (EHB) requirements will be reviewed and potentially revised in 2016, at which time there may be another opportunity to advocate for inclusion of MTFNI as a required benefit.

⁶⁹ For a list of United States Preventive Services Task Force (USPSTF) A and B Recommendations, see *USPSTF A and B Recommendations*, UNITED STATES PREVENTIVE SERVICES TASKFORCE, <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm> (last visited Dec. 1, 2013).

⁷⁰ Some states may have restrictions that prohibit entities from billing Medicaid for services that are provided for free to non-Medicaid clients, which may have an impact on the ability of Medically-Tailored Food and Nutrition Intervention Providers to bill Medicaid clients while continuing to offer their services free of charge to other non-Medicaid clients. However, this is not a requirement in federal Medicaid law. For a brief discussion of this issue in the context of the Ryan White Program, see NATIONAL ASSOCIATION OF STATE AND TERRITORIAL AIDS DIRECTORS AND THE HARRISON INSTITUTE FOR PUBLIC LAW, GEORGETOWN LAW, STATE HEALTH DEPARTMENT BILLING FOR HIV/AIDS AND VIRAL HEPATITIS: AN ANALYSIS OF LEGAL ISSUES IN FIVE STATES (Feb. 2013), 7-8, available at: <http://nastad.org/docs/NASTAD-Harrison-Report-HD-Billing-Legal-Regulatory-Challenges.pdf>.

In states that choose to establish MHHs, MTFNPs can move to establish relationships with these new care teams as a community-based resource for their MHH clients. MHH providers are committed to a team-based care structure that provides case management and connects high-needs patients to community-based services. This means that they are already attuned to their patients' whole health, and therefore likely to appreciate the value of MTFNI as a key component of effective care.

To make the case for inclusion of MTFNI in Medicaid, new Medicaid benefit packages, and Medicaid Health Homes, MTFNPs will need to demonstrate the potential for cost savings and health benefits. While available research supports the idea that the provision of medically-tailored home-delivered meals coupled with nutritional counseling is an effective intervention, MTFNPs will need to think strategically about how to track the impact of their services within their own client communities. As decision-makers realize the value of nutritional counseling and home-delivered meals, MTFNPs will have greater success in advocating for inclusion of their services in routine health care.

B. Medicare

Like Medicaid, Medicare offers reimbursement opportunities for MTFNPs. Individuals who are enrolled in Medicare Advantage or in a Medicare Special Needs Plan can receive home-delivered meals and nutritional counseling as part of their covered benefits under certain circumstances. The ACA has created new care delivery structures in Medicare called Accountable Care Organizations (ACOs). ACOs are incentivized to incorporate services that reduce the cost of care while improving health outcomes, making them excellent potential partners for MTFNPs.

Medicare: An Overview

Medicare is the federal health insurance program that covers most people over the age of 65 as well as disabled individuals regardless of age (disabled individuals must have been disabled for more than twenty-four months or have end-stage renal disease). Medicare offers four types of coverage: hospital insurance (Part A), medical insurance (Part B), Medicare Advantage (Part C) and prescription drug coverage (Part D). People enrolled in Part A and/or B receive coverage directly from Medicare, while people enrolled in Part C receive all Part A and B services through a private MCO.⁷¹ Unlike Medicaid, which is a state and federal partnership, Medicare is entirely a federal program, and benefits and eligibility are more consistent across states for Part A and B services.

⁷¹Medicare, SOCIAL SECURITY, <http://www.socialsecurity.gov/pubs/EN-05-10043.pdf> (last visited Dec. 1, 2013).

Medicare Coverage of Nutritional Counseling

Medicare covers medical nutrition therapy under its Part B services for people with non-dialysis kidney disease, diabetes, or who suffer from obesity, and those who have had a kidney transplant. All must first receive a referral from a doctor or health care provider.⁷² Medicare defines medical nutrition therapy as “nutritional assessment, one-on-one counseling, and therapy through an interactive telecommunications system provided by a registered dietitian or Medicare-approved nutrition professional.”⁷³ Registered dietitians may enroll directly as Medicare providers by obtaining a National Provider Identifier and completing the Medicare enrollment process.⁷⁴ The registered dietitian can then bill Medicare directly for nutritional counseling services.

Medicare Coverage of Home-Delivered Meals

In general, while Medicare Parts A and B cover some limited home health and long-term care services, they do not cover home-delivered meals.⁷⁵ However, under Medicare Part C (Medicare Advantage), individuals may choose to receive Medicare benefits through private MCOs, called Medicare Advantage (MA) plans. The federal government gives each MA plan a per-member per-month (PMPM) payment (similar to Medicaid MCOs) to provide standard Medicare services, and, like other MCOs, the plan assumes the risk if services cost more than the capitated amount.⁷⁶ Unlike general Medicare Part A and B services, MA plans can offer nutritional counseling to a broader array of beneficiaries by offering these services as a supplemental benefit.⁷⁷ MA plans may similarly provide coverage of home-delivered meals as a supplemental benefit under specific circumstances. In particular, MA plans may cover home-delivered meals “if the service is: 1) needed due to an illness; 2) consistent with established medical treatment of the illness; and 3) offered for a short duration.”⁷⁸ There are two specific circumstances under which MA plans can cover meals if the above criteria are met. First, meals may be offered to individuals immediately following surgery or an inpatient hospital stay, as long as the meals are only provided for a temporary period, and are ordered by a physician or non-physician practitioner. Second, meals may be covered for individuals with chronic

⁷² *Nutrition therapy services (medical)*, MEDICARE, <http://www.medicare.gov/coverage/nutrition-therapy-services.html> (last visited Dec. 1, 2013).

⁷³ *Id.*

⁷⁴ *The National Provider Identifier*, MEDICARE, http://www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/NationalProvIdentStand/downloads/npi_fs_geninfo_010906.pdf (last visited Dec. 3, 2013); *Medicare Enrollment for Physicians, Non-Physician Practitioners and Other Health Care Suppliers* 3 (2009), MEDICARE, available at <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/downloads/Suppliers.pdf>.

⁷⁵ *Home health services*, MEDICARE, <http://www.medicare.gov/coverage/home-health-services.html> (last visited Dec. 1, 2013).

⁷⁶ KAISER FAM. FOUND., MEDICARE ADVANTAGE FACTSHEET, (Nov. 25, 2013), available at <http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/>.

⁷⁷ *Medicare Managed Care Manual* 35-37, MEDICARE, <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf> (last visited Dec. 1, 2013).

⁷⁸ *Id.*

conditions like hypertension or diabetes, if such meals are ordered by a physician or non-physician practitioner, are provided for short period of time, and are part of a program intended to “transition the enrollee to lifestyle modifications.”⁷⁹

There are also specific kinds of MA plans, called Special Needs Plans (SNPs), that limit eligibility to certain targeted groups of individuals and that may offer benefits beyond those of regular MA plans. There are three kinds of SNPs: SNPs for different groups of individuals with certain specified chronic illnesses (C-SNPs);⁸⁰ institutional SNPs for individuals living in nursing homes or who require nursing care at home (I-SNPs), and dual eligible SNPs (D-SNPs).⁸¹ D-SNPs that participate in a particular Benefits Flexibility Initiative can choose to offer home-delivered meals at no additional cost to enrollees, and without the restrictions imposed on regular MA plans.⁸² SNPs are not available in every area, and states vary with regard to the types of SNPs that may be available.

In addition to home-delivered meal services specifically authorized by Medicare, some MA plans independently choose to offer coverage of home-delivered meals by partnering with nutrition service organizations such as Meals On Wheels, or by offering home-delivered meals as part of an expanded plan that recipients can obtain by paying extra money.⁸³ In both these instances, the meals are not considered an actual Medicare benefit.

Accountable Care Organizations (ACOs) in Medicare

Accountable Care Organizations (ACOs) are a new method of organizing care delivery and payment.⁸⁴ An ACO is a partnership of health care providers whose reimbursement is partially contingent on meeting quality metrics and reducing care costs. A group of providers, including but not limited to hospitals, managed care organizations, surgery centers, and physician practices, may apply to become an ACO under Medicare. There are several initiatives underway in which ACOs are working to provide better care coordination among Medicare Part A and B services to ensure better health outcomes and lower costs. For the first phase of these projects, the ACO providers will continue to receive fee-for-service reimbursement from Medicare for

⁷⁹ *Id.*

⁸⁰ For a list of the chronic conditions that make an individual eligible for C-SNPs, see *Guide to Medicare Special Needs Plans*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Nov. 2011) <http://www.medicare.gov/Pubs/pdf/11302.pdf> (last visited Dec. 1, 2013).

⁸¹ *Frequently Asked Questions About Special Needs Plans*, MEDICARE, <http://www.medicare.gov/sign-up-change-plans/medicare-health-plans/medicare-advantage-plans/special-needs-plans-faq.html#collapse-3318> (last visited Dec. 1, 2013).

⁸² *Note to All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties*, MEDICARE 105-109 (2012), available at <http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2013.pdf>.

⁸³ *Medicare Managed Care Manual 37*, MEDICARE, <http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf> (last visited Dec. 1, 2013).

⁸⁴ *Accountable Care Organizations*, CTRS. FOR MEDICARE & MEDICAID SERVS. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/> (last visited Dec. 1, 2013).

services provided under Medicare Part A and B. If the ACO meets Medicare-defined quality metrics, such as low readmission rates for patients with certain conditions who are treated by ACO providers, and the overall care costs for patients treated by the ACO are lower than predicted, Medicare will pay the ACO part of the cost savings it helped generate.⁸⁵ The ACO payment structure encourages providers to coordinate services and to pay close attention to patients' health outside of appointments, both to meet the quality requirements and to reduce overall costs.

Currently, most ACOs are in the early stages of development and bill Medicare on a fee-for-service basis for Part A and B services, which includes nutritional counseling only for certain individuals and does not cover home-delivered meals. Over time, ACOs that meet certain milestones for quality and cost-savings will move towards a capitated per-member per-month rate (PMPM, similar to the payment method for MCOs), which will allow them to have more flexibility in providing services that Medicare might not ordinarily cover.⁸⁶ This flexibility will create an opportunity for MTFNPs to contract with ACOs to provide non-traditional benefits that improve health outcomes and lower costs, like home-delivered meals.

Pursuing Medicare Reimbursement

As with Medicaid, Medicare offers opportunities for MTFNPs to receive reimbursement for nutritional counseling and/or home-delivered meals. For reimbursement of home-delivered meals, MTFNPs could partner with the Medicare Advantage (MA) plans in their state that offer home-delivered meals either as part of the plan's existing supplemental services or as part of a D-SNP, as well as with MA plans that offer additional home-delivered meal benefits outside of Medicare. MTFNPs could also reach out to MA plans that do not currently offer home-delivered meals to urge them to provide these services as a way to improve the health of their enrollees and cut down on costs. As with Medicaid HCBS, some MA plans may already have contracts for food services. MTFNPs should be prepared to make the case for why their services are unique and more likely to result in cost savings and improved health outcomes among the plans' enrollees.

ACOs' emphasis on delivering coordinated "whole-person" care in order to yield better outcomes aligns with the mission of MTFNPs, who have long recognized the critical role of nutrition services in achieving maximum health. To the extent that MTFNPs can demonstrate their expertise in providing nutrition services and show that these services play a huge role in

⁸⁵ *Accountable Care Organization 2013 Program Analysis*, CTRS. FOR MEDICARE & MEDICAID SERVS. 11, (Dec. 21, 2012), available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf>.

⁸⁶ See *Accountable Care Organizations*, CTRS. FOR MEDICARE & MEDICAID SERVS. <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO/> (last visited Dec. 1, 2013); *Pioneer Accountable Care Organization (AC) Model Program Frequently Asked Questions 3*, CTRS. FOR MEDICARE & MEDICAID SERVS. <http://innovation.cms.gov/Files/x/Pioneer-ACO-Model-Frequently-Asked-Questions-doc.pdf> (last visited Dec. 1, 2013).

reducing medical costs and improving the efficacy of medical treatment, they will be in a strong position to seek reimbursement for their services from an ACO.

C. Dual Eligible Programs: PACE and Integrated Care Organizations (ICOs)

Dual eligible programs provide care for low-income elderly or disabled people that are eligible for both Medicare and Medicaid. The populations that these programs serve are likely to have high medical needs, including the need for nutritional services. While there are many different dual eligible initiatives, this section examines the Program of All-Inclusive Care for the Elderly (PACE) as a potential partner for MTFNPs and discusses other dual eligible demonstration projects.

Overview and Opportunities: The Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) is a joint Medicare-Medicaid program (based on a capitation model) that states can implement to help keep elderly people in their homes and communities instead of in institutionalized care.⁸⁷ PACE Elder Service Plans (ESPs) provide all benefits authorized by Medicare and can also include a range of additional medical and social services, including nutritional counseling and home-delivered meals.⁸⁸ PACE programs are operated by non-profit agencies. Clients who enroll in a PACE ESP agree to receive health services only from their PACE ESP organization.⁸⁹ Thirty-one states currently have PACE programs, but services may not be available in every town. To qualify for PACE services, an individual must be age 55 or older, require a nursing facility level of care, and live within a PACE's service area.⁹⁰ In addition to dual-eligibles, PACE also serves individuals who meet these criteria who have only Medicare or Medicaid.⁹¹

As with HCBS waivers and Medicare, MTFNPs can partner with a PACE organization and receive reimbursement for providing MNT and home-delivered meals to the PACE's critically ill clients. MTFNPs should research whether their state currently offers PACE, and if so, which nonprofit entity administers the program.

⁸⁷ PACE, MEDICARE, <http://www.medicare.gov/your-medicare-costs/help-paying-costs/pace/pace.html> (last visited Dec. 1, 2013).

⁸⁸ *Id.*

⁸⁹ For a list of PACE programs in each state, see NATIONAL PACE ASSOCIATION, *PACE IN THE STATES*, (Jan. 1, 2013) available at http://www.npaonline.org/website/download.asp?id=1741&title=PACE_in_the_States.

⁹⁰ *Quick Facts about Programs of All-inclusive Care for the Elderly (PACE)*, CTRS. MEDICARE & MEDICAID SERV., [http://www.npaonline.org/website/download.asp?id=2378&title=Quick_Facts_about_PACE_\(CMS_Publication\)](http://www.npaonline.org/website/download.asp?id=2378&title=Quick_Facts_about_PACE_(CMS_Publication)) (last visited Dec. 3, 2013).

⁹¹ *Id.*

The ACA and Dual Eligible Demonstration Projects

Dual-eligibles demonstration projects experiment with new models of care delivery that aim to improve care for individuals who are dually eligible for both Medicaid and Medicare. These groups often require more health care services and incur more health-related costs than the general population. Because MTFNPs often serve individuals with complex health care needs, there may be significant overlap between the dual-eligible enrollees being targeted in these projects and clients in need of MTFNP services. Currently, for dual-eligible individuals, Medicare provides the bulk of primary care services, while Medicaid covers particular Medicare cost-sharing and premium requirements, and often provides direct coverage of long-term care services.⁹² Because each program covers different services and may involve different reimbursement methodologies, the provision of care can be inefficient. The new dual-eligibles demonstration projects aim to encourage new systems that provide better quality care for this population while lowering health costs. The ACA created the Medicare-Medicaid Coordination Office (MMCO) to assist states in integrating care for dual-eligibles as well as the Center for Medicare and Medicaid Innovation (CMMI), which is charged with testing, evaluating, and replicating innovative models of care.⁹³

For instance, Massachusetts began implementing a dual-eligibles demonstration project, “OneCare,” in spring 2013 whereby certain managed care groups, called Integrated Care Organizations (ICOs), receive a streamlined, capitated PMPM rate comprised of blended MassHealth (Medicaid) and Medicare funding.⁹⁴ The ICOs provide coordinated medical and behavioral health services, long-term care, and prescription drugs to dual-eligible individuals aged 21 to 64. Like MCOs, ICOs have discretion to provide additional benefits and community-based support as needed or requested by the client. They can also subcontract with other providers to offer these services. The overarching goal of Massachusetts’ ICO demonstration project is to provide coordinated services that result in better patient health outcomes and lower health costs.

⁹² For more information on Medicare and Medicaid dual eligibles generally, see KAISER FAMILY FOUNDATION, *MEDICARE’S ROLE FOR DUAL ELIGIBLE BENEFICIARIES* (2012), available at <http://www.kff.org/medicaid/upload/7846-03.pdf>.

⁹³ *State Demonstrations to Integrate Care for Dual Eligible Individuals*, CTR. MEDICARE & MEDICAID SERV., <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.html> (last visited Dec. 1, 2013); see also FAMILIES USA, *DUAL ELIGIBLE DEMONSTRATION PROJECTS: TOP TEN PRIORITIES FOR CONSUMERS ADVOCATES*, www.Communitycatalyst.org, http://www.communitycatalyst.org/doc_store/publications/Top_Ten_Duals_Projects_Guide_Advocates.pdf.

⁹⁴ For a general overview of the Massachusetts Dual Eligibles Demonstration Project, see KAISER FAM. FOUND., *MASSACHUSETTS’ DEMONSTRATION TO INTEGRATE CARE AND ALIGN FINANCING FOR DUAL ELIGIBLE BENEFICIARIES* (2012), available at <http://www.kff.org/medicaid/upload/8291-02.pdf>. For more detailed information on the Massachusetts project as well as current updates, see *Integrating Medicare and Medicaid for Dual Eligible Individuals*, MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES, <http://www.mass.gov/eohhs/provider/guidelines-resources/services-planning/national-health-care-reform-plan/federal-health-care-reform-initiatives/integrating-medicare-and-medicaid> (last visited Dec. 1, 2013); and *ONE CARE: Masshealth Plus Medicare*, MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES, <http://www.mass.gov/eohhs/consumer/insurance/onecare/> (last visited Dec. 1, 2013).

Many other states are undertaking similar dual-eligibles demonstration projects. These may present opportunities for MTFNPs to partner with ICOs or other provider entities to offer nutrition services as a means of improving health and lowering costs for a high-needs population.

Dual Eligible Programs: Opportunities for Advocacy

Both PACE and the new dual eligible demonstration projects initiated by the ACA may provide partnership or integration opportunities for MTFNPs to provide nutritional counseling and home-delivered meal services. Because dual eligible programs target enrollees with chronic conditions and significant health care needs, there may already be significant overlap between enrollees in a particular dual eligible program and a MTFNP's existing (or potential) client base. MTFNPs' contributions to holistic, preventive, and community-based care make them ideal partners to advance the goals of each of these models. In addition, partnerships with dual eligible demonstration programs can provide a key opportunity for MTFNPs to collect information to demonstrate their program efficacy, as MCOs/ICO may have the tools, infrastructure and incentive to collect detailed data on health and cost outcomes for participants.

D. Opportunities for MTFNPs Through Future Medicare and Medicaid Innovation Initiatives

Along with expanding eligibility and benefits, as well as creating new care delivery models described above, the ACA places a large emphasis on the development of new and innovative models of care and payment. In particular, the ACA established the Center for Medicare and Medicaid Innovation, which periodically issues Requests for Proposals for innovative care models. These grants present additional opportunities for MTFNPs to partner with health care providers and/or payors to evaluate the effect of providing nutrition services. Evaluating the effect of nutrition services could be the overarching goal of the proposal, or a tangential component (e.g., offering nutrition services to a target population as part of a larger project to evaluate alternative payment models). For example, CMMI recently released a request for proposals under its Health Care Innovation Awards Program to evaluate new payment models, and several different MTFNPs applied in partnership with health care providers and/or payors.⁹⁵ Partnerships with health care entities such as hospitals and/or MCOs are critical in pursuing opportunities with CMMI, because these entities will have experience with and capacity for more complex health care project planning, data collection, and evaluation that these grants often require and that MTFNPs may not have.

⁹⁵ The original Request for Proposal may be reviewed at: *Health Care Innovation Awards, CTRS. FOR MEDICARE & MEDICAID SERVS.*, <http://innovation.cms.gov/initiatives/Health-Care-Innovation-Awards/Round-2.html> (last visited Dec. 7, 2013).

Many state Medicaid programs are also looking for innovative ideas for improving care and reducing costs. For example, the New York Medicaid program recently created a new initiative to use state Medicaid funds to provide housing for some of its most medically vulnerable recipients.⁹⁶

As well, many hospitals that serve Medicare patients are searching for similar interventions due to new requirements in the ACA mandating that CMS reduce payments to hospitals with high numbers of patients who are readmitted to the hospital within 30 days of discharge. In particular, the Hospital Readmissions Reduction Program requires hospitals that provide acute inpatient services to meet these standards with respect to their Medicare patients age 65 and older who suffer from heart attacks, heart failure, and/or pneumonia.⁹⁷

As a result, many hospitals are now looking for new ideas to reduce readmissions for their Medicare patients, including the use of home-delivered meals. For example, Steward Health Care System in Massachusetts, which was penalized by this new Medicare law, recently initiated an experimental, time-limited program to provide home-delivered meals for 55 of their heart-failure patients in 3 of their hospitals.⁹⁸ In addition, Newton-Wellesley Hospital's Vernon Cancer Center recently began to provide home-delivered meals to some of their more vulnerable patients. These examples illustrate the willingness of some hospitals to think outside the box and look to home-delivered meals programs for solutions.⁹⁹

Again, the key to MTFNP success for integration into these initiatives will be in their ability to collect and use data to demonstrate the impact of nutrition services on health improvement and cost savings. The more that data demonstrates a positive impact on the specific quality metrics used to measure the performance of payors and/or providers in these new models, the more successful MTFNPs will be in forming future partnerships.

⁹⁶ See Matt Chaban, *Housing for the Homeless-Built With Medicaid Money*, NY DAILY NEWS, (Oct. 8, 2013) <http://www.nydailynews.com/new-york/bronx/housing-homeless-medicaid-money-article-1.1479796>; SUPPORTIVE HOUSING NETWORK OF NY, MEDICAID REDESIGN, <http://shnny.org/budget-policy/state/medicaid-redesign/> (last visited Dec. 7, 2013); *New York State Medicaid Redesign Team (MRT) Waiver Amendment*, NY STATE DEPT. OF HEALTH 57 (Aug. 6, 2012) available at http://www.health.ny.gov/health_care/medicaid/redesign/docs/2012-08-06_waiver_amendment_request.pdf.

⁹⁷ *Readmissions Reduction Program*, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html> (last visited Dec. 7, 2013); see also HEALTH AFFAIRS, HEALTH POLICY BRIEF, MEDICARE HOSPITAL READMISSIONS REDUCTION PROGRAM, (Nov. 12, 2013) available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_102.pdf.

⁹⁸ Liz Kowalczyk, *Healing Meals, Hospitals Hope That Sending Healthful Food to Patients' Homes Will Keep Them From Coming Back*, THE BOSTON GLOBE (June 10, 2013) <http://www.bostonglobe.com/lifestyle/health-wellness/2013/06/09/hospitals-reach-into-patients-homes-deliver-healthy-smoked-tofu-but-also-bbq-shrimp-scampi/QSqNQiyZUNxa9qbRWzs8l/story.html>.

⁹⁹ *Id.*

E. Private Insurance

Like public health insurance programs, private insurers also have a powerful incentive to adopt care innovations that reduce the cost of care for their neediest enrollees. Because MTFNPs provide a service that is proven to both reduce health care costs for high-need patients and improve outcomes, they are well-positioned to contract with private insurers for reimbursement of their services. In addition to contracting with individual private plans, MTFNPs can also advocate for strong federal and state-level requirements for the Qualified Health Plans (private insurance plans) sold in each state's online health insurance marketplace.

*Private Insurance and the ACA: An Overview*¹⁰⁰

Prior to the ACA, private insurers might have refused coverage to someone living with HIV/AIDS or other complex health conditions. Now, they can no longer refuse to cover any individual based on a pre-existing health condition, nor can they discriminate against medically-needy clients in administering coverage. Private health insurers can no longer charge a higher premium to women than to men. The ACA also prohibits private plans from containing annual or lifetime limits on coverage. This means that MTFNP clients are more likely to enroll in private insurance, and that private insurers will be motivated to find ways to reduce costs for clients they would have previously excluded.

In addition to making private health insurance more accessible for medically-needy individuals, the ACA will improve the ability of low-income individuals to afford private health insurance by providing premium tax credits and copayment subsidies. In every state (regardless of whether that state chooses to participate in the Medicaid expansion), people with incomes between 100 and 400% of FPL (between \$11,490 and \$45,960/year for an individual) who are not eligible for Medicaid will be able to receive tax subsidies to help them with private health insurance plans' premiums. In addition, people with incomes between 100 and 250% of FPL (between \$ 11,490 and \$28,725/year for an individual) will be eligible for subsidies to meet private health insurance plans' patient copayment obligations. These insurance plans, called Qualified Health Plans (QHPs) are available in every state through new, online marketplaces (also referred to as "exchanges"). In some states, these marketplaces are operated by the federal government, while in other states, marketplaces are run by the states themselves. Regardless of how the marketplace operates, individuals in every state are able to assess eligibility for tax credits and subsidies, compare health plans in terms of costs and covered services, and purchase QHPs through a single, streamlined application.

As with Medicaid, all QHPs (and most other private plans outside of the marketplace) will now have to provide coverage of all ten categories of Essential Health Benefits (EHBs) as well as coverage without cost-sharing of preventive services that receive an "A" or "B" rating from the

¹⁰⁰ For a comprehensive summary of the Affordable Care Act, see KAISER. FAM. FOUND., FOCUS ON HEALTH REFORM: SUMMARY OF THE AFFORDABLE CARE ACT, P.L. 111-148, (April 23, 2013) *available at* <http://kaiserfamilyfoundation.files.wordpress.com/2011/04/8061-021.pdf>.

USPSTF, including nutritional counseling for certain populations.¹⁰¹ The USPSTF gives a “B” rating to nutritional counseling “for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-related chronic disease.”¹⁰² Similar to Medicaid, EHB services will be defined in reference to a private health plan chosen by the state as a benchmark.¹⁰³ To the extent that a state benchmark covers MTFNI as part of an EHB category, all other private plans must match that coverage. Even if MTFNIs are not specifically included in the benchmark plan, EHB requirements represent the floor, not the ceiling, for private plans.

As more clients obtain private coverage, it will be important for MTFNPs to assess QHPs to determine the degree to which medical nutrition therapy or additional services such as home-delivered meals are covered. For example, the Georgia CoventryOne POS Plan, one of the QHPs offered in Georgia’s marketplace, includes coverage for education and nutritional counseling in connection with morbid obesity, pre-diabetes, diabetes, coronary artery disease, pregnancy, renal disease, hypertension, childhood obesity, eating disorders or hyperlipidemia, as long as these services are provided by a registered dietitian or provider.¹⁰⁴

Private Insurance Coverage of Medically-Tailored Food and Nutrition Intervention Services: Opportunities for Advocacy

Beyond covering USPSTF-recommended nutritional counseling services, there are no federal requirements for covering nutrition services such as home-delivered meals within any of the EHB categories. Because all states have already selected their private plan benchmarks, there is little room for state-based advocacy around private EHB requirements at this time. Nationally, however, advocates continue to urge the federal government to issue more comprehensive, federal EHB standards, and some groups continue to actively push for the inclusion of MNT and home-delivered meals, particularly for individuals with chronic health conditions.¹⁰⁵ Moreover, the federal standards for state EHBs will be reviewed and potentially revised in 2016, at which time states may consider whether to add additional services. To the extent MTFNPs may demonstrate improved health outcomes and reduced costs resulting from medical nutrition therapy and home-delivered meals, they may be in a better position to advocate for inclusion

¹⁰¹ 45 C.F.R. §156.100, et seq.; see also *Essential Health Benefits Bulletin*, (DEC. 16, 2011) CTRS. FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, available at

http://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf.

¹⁰² *USPSTF A and B Recommendations*, UNITED STATES PREVENTIVE SERVICES TASK FORCE, <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm> (last visited Dec. 1, 2013).

¹⁰³ For more information on state benchmark plans, see *Additional Information on Proposed State Essential Health Benefits Benchmark Plans*, CTRS. FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html> (last visited Dec. 9, 2013).

¹⁰⁴ COVENTRY HEALTH CARE OF GEORGIA, INC., COVENTRYONE POINT OF SERVICE (“POS”) INDIVIDUAL MEMBER CONTRACT, 25 (2014), available at

http://coventryone.com/web/groups/public/@cvty_individual_c1/documents/document/c074200.pdf.

¹⁰⁵ For more information on federal health reform advocacy on behalf of individuals living with HIV/AIDS, see HIV HEALTH REFORM, <http://www.hivhealthreform.org/> (last visited Dec. 1, 2013) as well as comments submitted by the Association of Nutrition Services Agencies (ANSA) in response to the EHB Bulletin of January 2012.

of nutrition services and home-delivered meals by 2016, either as their own category or as part of the required preventive services or chronic disease management categories.

As with Medicaid and Medicare, the ACA offers opportunities for MTFNI providers to build relationships with insurers to advocate for coverage of their services as critical interventions that reduce costs and improve quality. The most persuasive argument for MTFNI integration into private insurance is the intervention's potential for cost reduction, and MTFNPs should be prepared to explain the economic value of their services and project cost-savings for the insurer.

	Home and Community-Based Services (HCBS) 1915(c) Medicaid Waiver	1915(i) State Plan Amendment	1115 Research and Demonstration Waivers	Medicare Advantage
Funding Source	Medicaid	Medicaid	Medicaid	Medicare (Part C), and/or the plan via Supplemental Benefits
Target Client Population	Disabled or elderly (60+) people in need of a nursing facility level of care or higher	Individuals who need community based services but may or may not yet be at the point of requiring institutionalization	Broad flexibility to target groups and/or expand eligibility	Medicare-eligible individuals (those ages 65+ and disabled individuals)
Services Offered	Community-based medical and non-medical services (can include home-delivered meals)	Community-based medical and non-medical services (can include home-delivered meals)	Broad flexibility to offer expanded and/or non-traditional services like meals	Medical services (emphasis on physician and hospital services); can include home-delivered meals only in particular circumstances and for a short duration
Basic Structure	<p>Most states have some kind of HCBS 1915(c) waiver that allows them to provide non-traditional Medicaid services to disabled or elderly people to help those people live in the community instead of an institutionalized setting. States may select non-profit organizations to administer the HCBS 1915(c) waivers.</p> <p>The organizations evaluate people for eligibility and direct them to services for</p>	This amendment allows states to provide expanded HCBS specific services to targeted groups as part of a state plan rather than requiring a waiver.	Can be flexible-e.g., MA uses an 1115 waiver to provide Medicaid to all individuals with HIV up to 200% FPL; 1115 services could just be part of traditional Medicaid, create a separate program, address delivery reform, etc.	<p>Medicare Advantage Plans are MCOs for individuals in Medicare. In general, an MCO is paid a capitated rate to fund services for individuals, and bears the risk if overall services cost more than the capitation.</p> <p>An MCO has two parts: an insurer and a network. The insurer charges a set periodic fee and covers all client health services, as long as the client obtains services within the MCO's network. The network is a</p>

	<p>which they are eligible. Some states also use MCOs to deliver HCBS waiver services, and the evaluating organizations may also connect people with an MCO. The organizations may provide some waiver services directly and/or contract out for services.</p>			<p>group of care providers who have agreed to care for the MCO's clients in return for payment from the MCO.</p>
Operational Tenets	<ul style="list-style-type: none"> • Community-based living • Cost savings 		<ul style="list-style-type: none"> • Improving Medicaid services • Improving costs/budget neutrality requirement 	

	Accountable Care Organizations (ACO) Working with Medicare (new)	Program of All-Inclusive Care for the Elderly (PACE)	Dual Eligibles Projects, and/or Integrated Care Organizations (ICOs)
Funding Source	Medicaid, Medicare Parts A and B (Medicare fee-for-service), private coverage	Medicare (primary), Medicaid, individuals	Medicaid and Medicare jointly
Target Client Population	Medicare recipients, with a focus on people with high care needs	People 55+, in need of a nursing facility level of care or higher and within PACE organization's service area	People eligible for both Medicaid and Medicare, often targeting individuals with more complex health care and/or behavioral health needs
Services Offered	Medical services, with emphasis on coordination and community based supports	Medical services (includes range of community-based services, can include home-delivered meals, with an emphasis on preventive care)	Medical services (also can include range of community-based services)
Basic Structure	<p>An ACO is a tightly integrated provider-led network with a focus on improving quality and efficiency. An ACO shares in the funding source's savings if it reduces costs while maintaining quality, and may share in the funding source's losses if it raises costs.</p> <p>The ACO generally charges the funding source on a fee-for-service basis.</p> <p>The network of care providers works closely together and with the insurer to design care improvements that improve quality and reduce costs.</p>	<p>PACE is designed to keep elderly people in the community as long as possible. Medicare pays part of the set periodic payment to the PACE organization; Medicaid (if the client is a Medicaid member) and/or the client pay the remainder. The PACE organization's care providers (directly employed by the PACE organization) work closely to deliver services attuned to each individual. PACE clients must receive all medical services through the PACE organization.</p>	<p>An ICO is a specialized MCO for people dually eligible for Medicaid and Medicare participating in the new dual eligibles projects. The ICO receives one periodic payment from Medicaid and Medicare and covers all client health services.</p> <p>Using the patient-centered medical home (PCMH) model, the network of interdisciplinary care providers works closely together and with the insurer to deliver comprehensive, individualized care to a vulnerable population.</p> <p>The ICO has significant flexibility to design care programs that improve outcomes and keep clients in the community.</p>

Operational Tenets		<ul style="list-style-type: none"> • Community-based living • Cost savings 	<ul style="list-style-type: none"> • Payment efficiency/cost savings • Quality improvements in dual-eligible care
Making the Case for Partnership	<p>Every health organization listed above will want to know the same thing before partnering with an MTFNP: do home-delivered, medically-tailored meals improve long-term health outcomes for critically ill people and generate cost savings? MCOs, ACOs, ICOs and PACE organizations will need to know if partnership will benefit the organization in the long-term. PACE and waiver organizations need to know if partnership fits their goal of keeping critically ill people living in the community instead of in an institutional setting. The more research MTFNPs can produce that proves a link between home-delivered meals and better long-term health outcomes for chronically and critically ill people, the more willing the above health organizations will be to partner.</p>		

III. *Conclusion: Recommendations for Medically-Tailored Food and Nutrition Providers*

In a post-Affordable Care Act world, the health care landscape is rapidly evolving, favoring cost-effective innovations in care delivery that view the patient as a whole person with a set of varied and complex interrelated health needs. This period of dynamic change in health care access and delivery represents a unique opportunity for medically-tailored food and nutrition intervention services to become a widely-recognized core component of quality health care. Every health insurance program and private insurer is seeking to improve health outcomes while at the same time reducing the cost of care. The provision of nutritional counseling and medically-tailored, home-delivered meals to those with acute or chronic illnesses is a cost-effective intervention that produces measurable positive results for patients. It can shorten the length of a hospital stay, reduce the need for hospital admission, and increase the likelihood that a patient will be able to return to his or her home and community after a hospitalization.¹⁰⁶ Medically-tailored food and nutrition intervention providers (MTFNPs) are well-positioned to integrate their services into current and emerging health care delivery systems. This paper examined several opportunities for MTFNPs to expand both their client base and the ability to support their operations through reimbursement for meal-delivery and nutritional counseling services. We conclude by setting forth the following recommendations for MTFNPs as they move forward with efforts to integrate into new and existing health care programs and delivery models. Regardless of which program-specific opportunities individual MTFNPs choose to pursue, the implementation of these recommendations will create an environment that is conducive to integration of medically-tailored food and nutrition intervention services into health care delivery for people with chronic and acute debilitating illness.

1. **Become familiar with the administrative structure of your state's Medicaid program.** MTFNPs will need to understand how the Medicaid program operates and who or what entity has the ability to change its requirements, request waivers to expand coverage, move for amendments to the state plan, or design innovative demonstration projects.
2. **Advocate for expanding your state's Medicaid program in accordance with the ACA, and push for comprehensive Alternative Benefits Packages (ABPs) that include medically-tailored food and nutrition intervention services for newly eligible Medicaid beneficiaries.** Some states have declined to expand the Medicaid program to cover individuals up to 133% of the FPL. MTFNPs should continue to push for expansion, as many of their current clients will likely become eligible for coverage.

¹⁰⁶ Jill Gurvey, Kelly Rand, Susan Daugherty, Cyndi Dinger, Joan Schmeling, and Nicole Laverty, *Examining Health Care Costs Among MANNA Clients and a Comparison Group*, Journal of Primary Care & Community Health (June 2013), 4-5.

In states that are expanding Medicaid, MTFNPs should advocate for inclusion of their services in all ABPs and/or for the creation of special ABP packages that include medically-tailored food and nutrition intervention services for people with certain chronic and serious conditions.

- 3. Become familiar with the new coordinated care delivery models in your state.** New care delivery models created by the ACA emphasize outcome-driven coordinated patient care. States may choose to implement an Integrated Care Organization for dually eligible Medicaid-Medicare beneficiaries, Medicaid Health Homes for individuals with certain chronic conditions, or Accountable Care Organizations in Medicare. Innovation in care delivery is incentivized for these health care models, and MTFNPs are well-positioned to contract with them for client referrals and/or reimbursement of medically-tailored food and nutrition intervention services.
- 4. Evaluate MTFNI coverage and build relationships with private insurers who are offering new QHPs in your state's marketplace.** New tax credits and subsidies will expand access to the private health insurance market for low-income and medically vulnerable individuals for whom private insurance was previously unavailable. Private insurers looking to reduce health care costs for medically needy individuals are ideal partners for MTFNPs.
- 5. Advocate for inclusion of medically-tailored food and nutrition intervention services in Essential Health Benefits in 2016.** There is an opportunity to review and revise the federal requirements for the Essential Health Benefits (EHBs) package for both Medicaid and the private market in 2016. EHBs set the floor for coverage of different services in private insurance plans offered through the ACA marketplaces and for Medicaid coverage packages for people who become newly eligible through the Medicaid expansion. The inclusion of medically-tailored food and nutrition intervention services as a specific component of EHBs would dramatically increase the opportunities for MTFNPs to contract with Medicaid and private insurers, and for vulnerable MTFNP clients to receive the meals and nutritional support they need to heal and thrive.
- 6. Be prepared to make the case for why medically-tailored, home-delivered meals are different from other meal delivery programs.** Regardless of whether MTFNPs are proposing to contract with public or private health insurers, they will need to demonstrate that their services are uniquely appropriate for integration into preventive and acute medical care. MTFNPs will need to clearly articulate why their services will result in better health outcomes and lower costs for patients and insurers.
- 7. Form an ongoing data collection plan.** MTFNPs should be able to demonstrate the psychosocial and economic value of their program services by collecting and analyzing relevant client data.

Finally, we recognize that providing medically-tailored, home-delivered meals to people with chronic or acute illness is just one piece of a broader food as medicine revolution. Maintaining and regaining health begins with paying close attention to the quality of the food available to fuel our bodies every day. With diet-related chronic diseases on the rise, we cannot afford to ignore the role that food plays in preventing or exacerbating serious health conditions. Across the board, advocates should push for wider recognition of the strong link between food and health and support measures that help all people obtain the healthy, high-quality food they need to thrive. The services provided by MTFNPs are critical because they address the nutritional needs of those whose health is most vulnerable. In the broader movement to recognize food as a core component of health and health care, ensuring that health insurance translates into access to nutritious meals for the critically ill is an excellent place to start.

Appendix: Overview of Food Support Programs

This Appendix provides an overview of four federal food benefit programs which may offer additional funding opportunities for MTFNPs. Even when there are no current opportunities for MTFNPs to seek reimbursement through these programs, the program overviews may be helpful as MTFNPs think about how their services might evolve in the future and what programs exist to help fill existing nutritional gaps for their clients. The programs described here include: (i) the Supplemental Nutrition Assistance Program (SNAP), (ii) nutrition services funded by Title III of the Older Americans Act, (iii) the Child and Adult Care Food Program (CACFP), and (iv) the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). These programs exist to supplement the food needs of low-income and elderly individuals, and encompass a variety of distribution models, such as individual retail food benefits, home delivery through subsidized programs, and nutrition programs in child and adult care centers or communal living facilities.

i. SNAP: An Overview

The Supplemental Nutrition Assistance Program (SNAP) is a federally-funded and state-administered program that promotes access to nutritious food for low-income households.¹⁰⁷ SNAP benefits may be used toward “any food or food product intended for human consumption,” including frozen foods and meals,¹⁰⁸ but in general may not be used to purchase hot food or take-out food.¹⁰⁹ Beneficiaries use Electronic Benefits Transfer (EBT) debit cards automatically loaded with SNAP credits to purchase food at authorized retailers.¹¹⁰ Nationally, SNAP beneficiaries tend to underutilize the program: only 72% of SNAP-eligible persons and 41% of food insecure households are enrolled.¹¹¹

A household is eligible for SNAP benefits if its members meet certain income guidelines and it has \$2,000 or less in countable resources (\$3,000 in the case where at least one member is 60

¹⁰⁷ 7 C.F.R. § 271.1.

¹⁰⁸ 7 C.F.R. § 271.2.

¹⁰⁹ The Food Stamp Act of 1977 creates an exception to the hot foods restriction, authorizing states to create discretionary Restaurant Meals Programs expanding SNAP retailer eligibility to restaurants serving hot meals, although EBT payment at such locations is limited to elderly, disabled, or homeless beneficiaries. 7 C.F.R. § 278.1.

¹¹⁰ 7 C.F.R. § 274.7.

¹¹¹ Sheri Weiser, et al., *Food Insecurity is Associated with Greater Acute Care Utilization among HIV-Infected Homeless and Marginally Housed Individuals in San Francisco*, J. OF GEN. INTERNAL MED. (2012). The United States Department of Agriculture (USDA) defines food security as “access by all members at all times to enough food for an active, healthy life. Food security includes at a minimum: (1) the ready availability of nutritionally adequate and safe foods; and (2) assured ability to acquire acceptable foods in socially acceptable ways (that is, without resorting to emergency food supplies, scavenging, stealing, or other coping strategies).” See *Food Security*, U.S. DEPT. OF AGRIC., <http://www.fns.usda.gov/fsec/> (last visited Dec. 7, 2013). By contrast, “food insecurity” is limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways. For more information on food insecurity and how it is measured, see *Food Insecurity*, ECONOMIC RESEARCH CENTER, U.S. DEPT. OF AGRIC., <http://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-us/measurement.aspx#insecurity> (last visited Dec. 7, 2013).

years of age or older, or disabled).¹¹² As discussed below, there are a number of different ways that an MTFNMTFNP could become authorized to accept SNAP benefits from clients. Three main options include being authorized as a retail food store, as a meal-delivery program, or as a communal dining facility or group living arrangement.

*Authorization as a Retail Food Store*¹¹³

A store can become an eligible food retailer under SNAP if it meets one of criteria: (1) it sells on a continuous basis at least three foods from each of four staple categories (breads/cereals, fruit/vegetables, meat/fish/poultry, and dairy products) and at least two of the categories sold include perishable foods; or (2) over fifty percent of the store's gross sales consists of staple foods.¹¹⁴ Frozen meals are included in the staple food category of the main ingredient (as determined by the USDA Food and Nutrition Service (FNS)) and count as one staple variety.¹¹⁵ Staple foods do not include coffee, tea, cocoa, soda, candy, condiments, spices, and prepared, ready-to-eat foods.¹¹⁶ Vendors interested in becoming authorized to receive SNAP payments can contact a local FNS field office to file an application.¹¹⁷ Amendments to the 2014 Farm Bill directed the USDA to issue regulations that add "governmental or private nonprofit food purchasing and delivery services" to the definition of "Retail Food Store" if the service met three requirements. First, the service must purchase food for and deliver food to individuals who are unable to shop for food and are either older than 60 or physically or mentally handicapped. Second, the service must notify the purchasing households of any delivery fee associated with the transaction (SNAP recipients may not use SNAP benefits to pay the delivery fee). Third, the service must sell meals at the price the service has paid for the food without any additional cost markup.¹¹⁸ The future regulations based on these amendments may offer additional opportunities for MTFNMTFNPs to receive SNAP benefits beyond becoming authorized as a meal delivery service (addressed below).

Authorization as a Meal Delivery Service

In addition to retail food stores, organizations that provide meal delivery services to certain categories of eligible SNAP beneficiaries can also become authorized to accept SNAP.¹¹⁹ To

¹¹² 7 C.F.R. § 273.8(b); General information on SNAP eligibility may be found at *Supplemental Nutrition Assistance Program Eligibility*, U.S. DEPT. OF AGRIC., <http://www.fns.usda.gov/snap/eligibility> (last visited Dec. 7, 2013); 7 C.F.R. § 273.9 (2012).

¹¹³ See generally, *Retail Store Eligibility USDA Supplemental Nutrition Assistance Program*, U.S. DEPT. OF AGRIC., <http://www.fns.usda.gov/snap/retail-store-eligibility-usda-supplemental-nutrition-assistance-program> (last visited Dec. 7, 2013).

¹¹⁴ 7 C.F.R. § 278.1 (b).

¹¹⁵ 7 C.F.R. § 278.1 (b)(1)(ii)(C).

¹¹⁶ 7 C.F.R. § 278.1 (b) (eligible retailers include organizations with stationary stores which make home deliveries to SNAP households). Note that "perishable" can include staple foods that are frozen.

¹¹⁷ *Store Owner's Guide to SNAP Food Stamps*, MASSRESOURCES.ORG, <http://www.massresources.org/snap-store-owners-guide.html#apply> (last visited Dec. 7, 2013).

¹¹⁸ 7 U.S.C. § 4003 (b).

¹¹⁹ 7 C.F.R. § 278.1 (d).

qualify under the meal delivery category, a program must generally be a nonprofit organization that contracts with the state or local agency to prepare and provide lower-cost meals to elderly individuals (60 years of age or older) and to individuals who are physically or mentally disabled to the extent that they are “unable to adequately prepare all of their meals.”¹²⁰ Spouses of these eligible individuals can also receive meals.¹²¹ There are similar restrictions on the categories of individuals who are allowed to use their benefits to pay for home-delivered meals. Only SNAP-eligible individuals 60 years of age or over, or SNAP-eligible individuals who are housebound and disabled to the extent that they are unable to adequately prepare all their meals and their spouses, may use SNAP benefits to purchase home-delivered meals from an authorized provider.¹²²

Meal delivery services authorized under this category may operate as one of two models. They may either sell meals to beneficiaries or accept voluntary donations from beneficiaries. Under the first model, a retailer or other service charges all of its clients for its services. For example, Somerville-Cambridge Elder Services of Massachusetts currently provides home-delivered hot meals via its Meals-on-Wheels Program and accepts SNAP as payment from enrollees.¹²³ In this model, the vendor may also allow individuals to purchase meals with funds other than SNAP benefits. Under the donation model, a retailer or other program provides its services for free, but accepts voluntary payments from clients who wish to contribute. In this model, enrolled SNAP beneficiaries may make voluntary donations of their benefits in an amount of their choosing. Northwest Senior & Disability Services of Oregon, for instance, accepts donations of SNAP benefits for its Meals-on-Wheels programs.¹²⁴

Authorization as a Communal Dining Facility or Group Living Arrangement

Finally, certain communal dining facilities and group homes can also collect SNAP payments from their residents for meals served in those facilities.¹²⁵ To be authorized as a communal dining facility, an entity must be a public or private establishment that prepares and serves meals to individuals over age 60 or to persons receiving Social Security Income (SSI).¹²⁶ To be eligible as a group living arrangement, an entity must be a state-certified public or private nonprofit residential setting serving no more than sixteen residents.¹²⁷ An entity authorized as a group living arrangement can only receive SNAP payment from residents of the home who are blind or disabled.¹²⁸

¹²⁰ 7 C.F.R. § 271.2.

¹²¹ *Id.*

¹²² 7 C.F.R. § 274.7(2)(g).

¹²³ *Nutrition Services*, SOMERVILLE-CAMBRIDGE ELDER SERVICES, http://www.eldercare.org/Services_Nutrition/Nutrition_MainPage.shtm (last visited Dec. 7, 2013).

¹²⁴ *Food Stamp Donation*, NORTHWEST SENIOR & DISABILITY SERVICES, <http://www.nwsds.org/meals-on-wheels/donations/food-stamp-donation/> (last visited Dec. 7, 2013).

¹²⁵ 7 C.F.R. § 278.1 (f).

¹²⁶ 7 C.F.R. § 271.2.

¹²⁷ *Id.*

¹²⁸ *Id.*

SNAP: The Take-Away

MTFNPs that deliver staple foods to elderly or disabled people who are unable to prepare their own meals are most likely to be able to qualify as vendors under the home-delivered meals programs category. However, there are several issues for an MTFNP to consider before deciding to seek authorization as a SNAP vendor. First, no vendor of any type can treat SNAP beneficiaries any differently than other clients, meaning that if the vendor allows some individuals (who do not have SNAP benefits, for example) to receive meals for free, it cannot require other individuals to use their SNAP benefits, but can only request or suggest a voluntary SNAP donation.¹²⁹ Therefore, unless a MTFNP began charging all of its clients, the MTFNP could not require SNAP payment from anyone, but instead could only accept donations. If an MTFNP's clients are largely eligible for SNAP but do not exhaust their benefits every month, the MTFNP could consider charging a low fee for meals to all clients, and allowing SNAP beneficiaries to use their SNAP benefits as payment. For MTFNPs who would like to retain their original ability to offer services free of charge to those who need it, and/or whose clients either do not qualify for SNAP or use all of their SNAP dollars every month, the donation model may be more appropriate.

Second, as with health coverage options, in assessing the possibilities of accepting SNAP payments, an MTFNP would also need to weigh the administrative costs of accepting payment against the likely benefits. Administrative costs include the cost of adopting the technology required to accept SNAP benefits, such as electronic Point-of-Sale terminals capable of processing EBT cards. A wireless POS terminal can cost up to \$1000 to install and program, plus monthly charges or fees on transactions.¹³⁰ However, if an MTFNP averages \$100 per month in SNAP transactions, it may borrow a POS terminal from the government for free. In the alternative, if a vendor averages less than \$100 per month, or lacks electricity or a phone line, vendors may fill out paper vouchers for each transaction.¹³¹

Third, to gain an accurate assessment of the potential financial benefits, an MTFNP would need to know the percentage of its clients eligible for SNAP and the amount of SNAP benefits those clients have left at the end of the month, if any. If many of the MTFNP's clients are SNAP-eligible but do not use all of their benefits, developing a strategy whereby the MTFNP incorporated donated SNAP benefits into its program could be framed as a way to allow clients to give back to the MTFNP and support the provision of meals to themselves and others.

¹²⁹ 7 C.F.R. § 278.2(b).

¹³⁰ AMANDA BAESLER, MINN. DEP'T OF AGRIC., HOW TO IMPLEMENT SNAP AND EBT INTO YOUR FARMERS' MARKET 16-17 (2010), available at <http://www.mda.state.mn.us/food/business/~media/Files/food/business/implementsnapebt.ashx>.

¹³¹ *How to Accept SNAP Benefits at Your Store*, U.S. DEPT. OF AGRIC., <http://www.fns.usda.gov/snap/retailers/accepting-benefits.htm> (last visited Dec. 7, 2013).

ii. Title III of the Older Americans Act: An Overview

Title III of the Older Americans Act authorizes the Nutrition Services Program for the elderly. This program provides grants to state agencies on aging to support congregate and home-delivered meals to individuals over the age of 60.¹³² One of the program's core missions is "to promote the health and well-being of older individuals by assisting such individuals to gain access to nutrition and other disease prevention and health promotion services to delay the onset of adverse health conditions resulting from poor nutritional health or sedentary behavior."¹³³ States route Title III funding to Area Agencies on Aging (AAAs), which in turn support nutrition services, including home-delivered meal programs.¹³⁴ In Massachusetts, for example, eligible individuals receive services through AAAs and/or Massachusetts' Elderly Nutrition Program sites.¹³⁵ These sites provide services directly or contract with other providers. Such home-delivered meal programs must provide meal recipients with at least one meal per day at least five days per week (unless a lesser frequency is approved by the state agency), and frozen meals are explicitly authorized by the statute.¹³⁶ Funded programs must also provide "nutrition education, nutrition counseling, and other nutrition services . . . based on the needs of the meal recipients."¹³⁷ There is no income test for these services, but recipients must be aged 60 or older, and homebound.¹³⁸ The spouse of the recipient is also eligible. Services may also be available to individuals under age 60 with disabilities or who are handicapped, if they reside in a housing facility occupied primarily by the elderly.¹³⁹

Title III: The Take-Away

Similar to the partnerships described in the health section, an MTFNP could consider contracting with an AAA to support its home-delivered meals program.¹⁴⁰ The main concern with such a contract is the low meal reimbursement rate. The primary goal of the OAA Nutrition Services program is to prevent hunger, rather than treat or prevent illness. By contrast, MTFNPs may produce a wide variety of medically-tailored meals to serve people with a variety of critical illnesses, and in doing so run higher operational costs than hunger-focused programs. Therefore, while an MTFNP may be eligible to partner with an AAA and receive funds through

¹³² KRISTEN J. COLELLO, CONG. RESEARCH SERV., RS21202, OLDER AMERICANS ACT: TITLE III NUTRITION SERVICES PROGRAM, 1 (2010).

¹³³ 42 U.S.C. § 3030d-21.

¹³⁴ *Area Agency on Aging*, CITY OF BOSTON.GOV, <http://www.cityofboston.gov/elderly/agency.asp> (last visited Dec. 6, 2012); *Area Agency on Aging*, MASS.GOV, <http://www.mass.gov/elders/area-agency-on-aging.html> (last visited Dec. 7, 2013).

¹³⁵ For a list of program sites, see *Massachusetts Elderly Nutrition Program Sites*, MASS. EXEC. OFF. ELDER AFF., <http://www.mass.gov/elders/meals-nutrition/mass-elderly-nutrition-program-sites.html> (last visited Dec. 7, 2013).

¹³⁶ 42 U.S.C. § 3030f(1).

¹³⁷ 42 U.S.C. § 3030f(2).

¹³⁸ *Home-delivered Meals Who Qualifies?*, MASS. EXEC. OFF. ELDER AFF., <http://www.mass.gov/elders/meals-nutrition/home-delivered-meals.html> (last visited Dec. 7, 2013).

¹³⁹ *Id.*

¹⁴⁰ Currently, three AAAs in Boston provide home-delivered meals to the elderly. *Area Agency on Aging*, CITY OF BOSTON.GOV, <http://www.cityofboston.gov/elderly/agency.asp> (last visited Dec. 7, 2013).

the OAA for serving home-bound seniors, the OAA will likely pay the MTFNP far less than it costs the MTFNP to produce and distribute the meals to those seniors. In order to determine whether funding under this program may be a viable option, MTFNPs should contact their local Area Agencies on Aging to learn more about reimbursement levels and contracting requirements. As with other programs, MTFNPs should also assess eligibility among their existing clients, decide whether to take on additional clients, and weigh participation costs against the likely reimbursement amount.

iii. The Child and Adult Care Food Program: An Overview

The Child and Adult Care Food Program (CACFP) is a federally funded and state administered program that enables nonresidential child and adult care institutions to integrate provision of nutrition services and meals with day care services.¹⁴¹ The program reimburses child and adult day care programs for meals they provide to their clients as long as the meals meet specific nutrition requirements.¹⁴² Reimbursement rates vary depending on the income of the individuals and/or families served by the program.¹⁴³ Unlike SNAP, program benefits are distributed to care centers rather than to individuals or households. A care center may contract with a food service company.¹⁴⁴

Federal regulations pertaining to CACFP define “adult day care center” as a government-approved organization that provides nonresidential adult day care services to functionally impaired or elderly adults (adults over age 60) in a group setting outside their homes, or in a group living arrangement on a less than 24-hour basis.¹⁴⁵ A person is “functionally impaired” if she is physically or mentally impaired to the extent that her ability to live independently or carry out activities of daily living is “markedly limited.”¹⁴⁶ Adult day care centers must provide enrollees with a structured, community-based group program that includes a variety of health and social support services, and is based on an individual plan of care.¹⁴⁷ Government-approved child care centers (non-residential), settlement houses, neighborhood centers, and Head Start programs, among other organizations, are also eligible for CACFP reimbursement.¹⁴⁸

¹⁴¹ 7 C.F.R. § 226.1; For general information about the Child And Adult Care Food Program, see *Child And Adult Care Food Program*, U.S. DEPT. OF AGRIC., <http://www.fns.usda.gov/cacfp/child-and-adult-care-food-program> (last visited Dec. 7, 2013).

¹⁴² Specific nutrition and meal requirements can be found at: 7 C.F.R. § 226.20.

¹⁴³ 7 C.F.R. § 226.9.

¹⁴⁴ 7 C.F.R. § 226.21; 7 C.F.R. § 226.19a(b)(2).

¹⁴⁵ 7 C.F.R. § 226.2.

¹⁴⁶ *Id.* Activities of daily living include “cleaning, shopping, cooking, taking public transportation, maintaining a residence, caring appropriately for one’s grooming or hygiene, using telephones and directories, [and] using a post office.” Note that “marked limitations refer to the severity of impairment, and not the number of limited activities, and occur when the degree of limitation is such as to seriously interfere with the ability to function independently.”

¹⁴⁷ 7 C.F.R. § 226.19a(b)(2).

¹⁴⁸ 7 C.F.R. § 226.17(b)(1), 226.2.

CACFP: The Take-Away

To the extent that MTFNPs provide hot congregate meals at adult day care centers, CACFP reimbursement may be a way to defray the cost of these services.

iv. WIC: An Overview

The Special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a federally funded and state administered program that provides supplemental foods, health care referrals and nutrition education to low-income pregnant, postpartum and breastfeeding women, and infants and children up to age five who are at risk of poor nutrition.¹⁴⁹ A food retailer is eligible to receive WIC benefits as payment for its goods if it meets state-determined inventory requirements.¹⁵⁰ In Massachusetts, for example, vendors must “operate a permanent, fixed, retail establishment” and accept SNAP benefits, among other requirements.¹⁵¹ The WIC program has more stringent inventory requirements than SNAP. In Massachusetts, WIC-authorized businesses must provide juice, cheese, cereal, dairy and soy milk, eggs, iron-fortified infant cereal, infant formula and baby food, peanut butter, beans and peas, tuna, fruits, vegetables, whole grain bread, tortillas, tofu, salmon and sardines.¹⁵² Prepared meals, frozen or hot, are not on the list of covered items.

Although WIC has more stringent requirements for inventory, there is flexibility in the kinds of operational models that may become WIC vendors.¹⁵³ In particular, states can authorize retailers, home delivery or direct distributors.¹⁵⁴ For example, WIC in Vermont is primarily administered through home delivery.¹⁵⁵ Each state WIC program is different however, and not every state may allow home-delivery vendors. Entities wishing to become authorized as WIC vendors must apply through their state or local WIC agency.

WIC: The Take-Away

¹⁴⁹ 7 C.F.R. § 246.1.

¹⁵⁰ *Massachusetts Women, Infants and Children Program Vendor Application Packet*, MASS. EXEC. OFF. HEALTH AND HUM. SERVS., <http://www.mass.gov/eohhs/docs/dph/wic/vendor-app-packet.pdf> (last visited Dec. 7, 2013).

¹⁵¹ 7 C.F.R. § 246.12; see also *Massachusetts Women, Infants and Children Program Vendor Application Packet*, MASS. EXEC. OFF. HEALTH AND HUM. SERV., <http://www.mass.gov/eohhs/docs/dph/wic/vendor-app-packet.pdf> (last visited Dec. 7, 2013).

¹⁵² *Massachusetts Women, Infants and Children Program Vendor Application Packet*, MASSACHUSETTS EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES, <http://www.mass.gov/eohhs/docs/dph/wic/vendor-app-packet.pdf> (last visited Dec. 7, 2013).

¹⁵³ 7 C.F.R. § 246.12 (b).

¹⁵⁴ *Id.*

¹⁵⁵ *Better Food, Better Health*, VERMONT.GOV, http://healthvermont.gov/wic/food-feeding/wic-foods/Food_list.aspx (last visited Dec. 7, 2013).

MTFNPs may already provide many of the staple foods that are provided to WIC participants. Some MTFNPs deliver bags of staple foods instead of prepared meals to clients who cannot shop for themselves but are able to cook. In states that allow home delivery of WIC foods, these MTFNPs could seek to become WIC vendors. However, each delivered food package must comply with WIC's strict requirements.

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